

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|---------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------|-------------------------------|
| 65 9501 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9501 | |
| BIRTH NO. | | <div style="font-size: 2em; font-weight: bold;">GEORGIA P. Ecker</div> | | <div style="font-size: 1.5em; font-weight: bold;">9-14-65</div> | |
| M.E. CASE NO. | | | | DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 3130 HOWARD PARK Ave | | A. STATE | | B. COUNTY | |
| | | MD | | 28-02 | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | BALTIMORE | | | |
| | | 3130 HOWARD PARK Ave | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months: Days |
| Female | White | Widowed | JULY 21, 1879 | 86 | 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTH PLACE (State or foreign country) | |
| AT Home | | | | BALTO | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| SAMUEL JONES | | TIMMONS | | USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | None | | RAYMOND ECKER - 1916 GUERNSEY Ave | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the made at dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | Coronary Occlusion | |
| ANTECEDENT CAUSES | | (B) DUE TO | | Coronary Insufficiency | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | Ischemic - Myocardial | |
| | | | | Congestive | |
| | | | | Myocardial | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-23-65 to 9-14-65, that (I) (we) last saw the deceased alive on 9-13-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 1 PM | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| Dr. Thos. J. Affert | | | | 9-15-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| | | M.D. 4509 Liberty Heights & Balto. Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Burial | | 9/17/65 | | Loudon Park Cemetery - Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| SEP 16 1965 | | R. E. Fairbank | | Ellsworth Armacost - 4600 Liberty Heights Ave | |



40



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|---------------------------------------------------------------------------------------------|------------------------------------------|
| BIRTH NO. 65 9502 | | CERTIFICATE OF DEATH | | 65 9502 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) BINKOWSKI, JOSEPHINE | | 2. DATE AND HOUR OF DEATH 9-14-65 4:35 PM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland 8. COUNTY 2-02 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION 35 Church Home & Hospital | | D. STREET ADDRESS (If rural, give location) 124 S. Durham St. | | | |
| 5. SEX female | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 7-11-1901 | 9. AGE (In years, most birthday) 64 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) presser | | 10B. KIND OF BUSINESS OR INDUSTRY MENS WEAR | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME ANTHONY NOWICKI | | 14. MOTHER'S MAIDEN NAME JULIANA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO. | | 16. SOCIAL SECURITY NO. 217-14-2539 | | 17. INFORMANT STANLEY BINKOWSKI SR. | |
| | | ADDRESS 134 S. DURHAM ST. BALTO. MD. 21231 | | | |
| 18. 260X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) cerebral hemorrhage RT | | CAUSE OF DEATH (A) cerebral hemorrhage RT | | INTERVAL BETWEEN ONSET AND DEATH 23 days | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) hypertension, essential | | years | |
| | | (C) diabetes mellitus | | years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 9-14-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-22-65 to 9-14-65 , that (I) (we) last saw the deceased alive on 9-14-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Jose S. Maisog MD. | | | | 23B. DATE SIGNED 9-14-65 | |
| 23C. PHYSICIAN'S NAME (Type) Jose S. Maisog MD. | | | | 23D. ADDRESS Church Home & Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-18-65 | | 24C. NAME OF CEMETERY or CREMATORY ST. STANISLAUS CEM. BALTO., MD. | |
| 24D. LOCATION (City, town, or county) (State) BALTO., MD. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 16 1965 | | 25B. NAME OF REGISTRAR Wm. Fialkowski | |
| 25C. FUNERAL DIRECTOR Wm. Fialkowski | | 25D. ADDRESS 2007 EASTERN AVE. BALTO., MD. 21231 | | | |

BRUNNEN, 1000 1/2

1000 1/2

1000 1/2

1000 1/2

1000 1/2

1000 1/2

1000 1/2

1000 1/2

1000 1/2

1000 1/2

65 9503

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 9503

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE THOMPSON

2. DATE AND HOUR PRONOUNCED DEAD

September 9, 1965 6:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

33

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

5-01

D. STREET ADDRESS (If rural, give location)

1238 Edythe Street

5. SEX

male

6. RACE

negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

April 1903

9. AGE (In years
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Wash., D.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

George Thompson

14. MOTHER'S MAIDEN NAME

Jumima Ransom

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Raymond Hopps 2021 Lewellyn Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/8/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/14/65

23C. NAME OF CEMETERY or CREMATORY

Mt Calvary Cemetery

23D. LOCATION

(City, town, or county)

(State)

Ann Arundel County, Maryland

24A. DATE REC'D BY HEALTH DEPT.

SEP 16 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Wm C March 928 E. North Ave.

WALLEN FORD

NOV 1963

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 15-2-65 9504 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9504 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) James Richard Hancock | | | 2. DATE AND HOUR OF DEATH 9-14-1965 8:50 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21217 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 14-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1401 Myrtle Avenue 21217 | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married | 8. DATE OF BIRTH 4-6-1944 | 9. AGE (In years last birthday) 21 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Richard Hancock | | | 14. MOTHER'S MAIDEN NAME Mary | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-40-8855 | 17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224 | | |
| 18. 490X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Lobar Pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH (A) Lobar Pneumonia DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 48 hours | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-13-1965 to 9-14-1965 , that (I) (we) last saw the deceased alive on 9-14-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Ben F. Hughes M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 9-14-1965 | |
| 23C. PHYSICIAN'S NAME (Type) Benjamin Hughes | | | | 23D. ADDRESS M.D. 4940 Eastern Avenue, Baltimore, Maryland | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9/18/65 | 24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery | | 24D. LOCATION (City, town, or county) (State) Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 16 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR ADDRESS Wm. C. March, 928 E. North Ave. | |

FUNERAL DIRECTOR: IMPORTANT

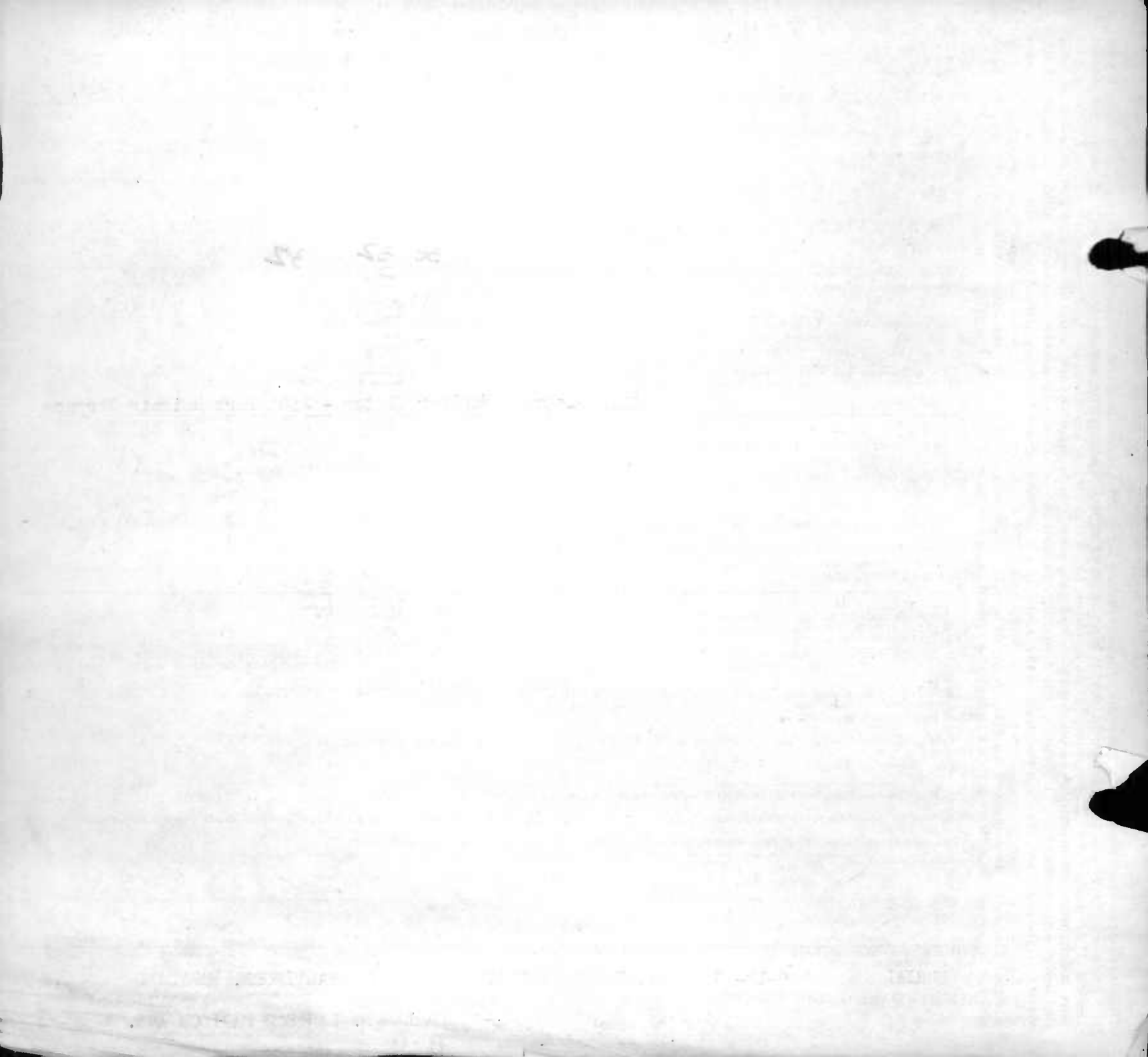
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital, and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. 65 9505 | | M.E. CASE NO. 5630 | | Certificate of Death | |
| 1. NAME OF DECEASED (Type or Print) Nina Sherard <i>SHEAROCK</i> | | | 2. DATE AND HOUR OF DEATH 10x 9-15-65 10:35a.m. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>33</i> The Johns Hopkins Hospital | | | A. STATE Maryland <i>8-06</i> | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) 100 1606 North Chester Street | | |
| 5. SEX <i>M</i> Female Male | 6. RACE <i>Negro</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widow</i> | 8. DATE OF BIRTH 3-11-83 | 9. AGE (In years lost birthday) 82 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>unemployed</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>North Carolina</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | 13. FATHER'S NAME <i>Jesse Foster</i> | | |
| 14. MOTHER'S MAIDEN NAME <i>Cora Vick</i> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT <i>Gula Mae Astell</i> ADDRESS <i>same</i> | | |
| 18. <i>422.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>ASCVD</i> | | | INTERVAL BETWEEN ONSET AND DEATH <i>20 YRS.</i> | | |
| ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>YES</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <i>(this hospital)</i> attended the deceased from <i>9/10</i> 19 <i>65</i> to <i>9/15</i> 19 <i>65</i> , that <i>(I (we))</i> last saw the deceased alive on <i>9/15</i> 19 <i>65</i> and that in <i>(my) (our)</i> opinion death occurred on the date and hour and from the causes stated above. <i>(We) (did)</i> (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>J. R. Spencer</i> | | | | 23B. DATE SIGNED <i>9/15/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>J. R. SPENCER</i> | | | | 23D. ADDRESS <i>Johns Hopkins Hosp.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>9-19-65</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Red Hill Cmt</i> | |
| 24D. LOCATION (City, town, or county) <i>North Carolina</i> | | 24E. (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 16 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Jackson</i> | | 25C. FUNERAL DIRECTOR <i>Hammit's Home</i> | |
| 25D. ADDRESS <i>Hammit's Home</i> | | 25E. ADDRESS <i>Hammit's Home</i> | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
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| BIRTH NO. 65 9506 | | | | | CERTIFICATE OF DEATH | | | Registered No. 65 9506 | |
| M.E. CASE NO. | | | | | DATE AND HOUR OF DEATH | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Naelmer Maddelaine Anderson</u> (STATEN) | | | | | Sept 13, 1965 2:10 P.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>University Hosp.</u> | | | | | A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> | | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | | | D. STREET ADDRESS (If rural, give location) <u>2511 Park Heights Terrace</u> | | | | |
| 5. SEX <u>F</u> | 6. RACE <u>N.</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Separated</u> | 8. DATE OF BIRTH <u>9-30-32</u> | 9. AGE (In years lost birthday) <u>32</u> | If Under 1 Tr. Months | | If Under 24 Hrs. Days | | Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Nurse</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 13. FATHER'S NAME <u>Henry Young</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Fannie Staten</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. <u>214-30-5673</u> | | 17. INFORMANT ADDRESS <u>Naelmer Staten - 2504 Park Heights Terrace</u> | | | | |
| 18. <u>446X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | | CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | | | | (A) <u>Cerebral Vascular Hemorrhage</u> DUE TO | | | <u>1 hr.</u> | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (B) <u>Malignant Hypertension</u> DUE TO | | | <u>5 mos?</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPST? (Yes or No) <u>yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12:30 pm 9-13 1965</u> to <u>2:10 pm 9-13 1965</u> , that (I) (we) lost saw the deceased olive on <u>2:10 9-13 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>J C Hisley</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED <u>9-13-65</u> | | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>John C. Hisley</u> M.D. | | | | | 23D. ADDRESS <u>University Hosp</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>9-17-65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>BALTIMORE NATIONAL</u> | | 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 16 1965</u> | | 25B. NAME OF REGISTRAR <u>John E. Farley</u> | | 25C. FUNERAL DIRECTOR <u>CHARLES R. LAW</u> | | 25D. ADDRESS <u>802 MADISON AVE.</u> | | | |



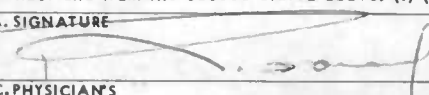
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9507 | |
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| BIRTH NO. 65 9507 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) LUCY B. SMITH. | | 2. DATE AND HOUR OF DEATH SEPTEMBER 13 1965 AT 12.P.M. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND 307 DOLPHIN STREET <small>Full name of hospital or institution, give street address or location</small> | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 11-04 | | | |
| 5. SEX FEMALE | | 6. RACE COLORED | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW | |
| 8. DATE OF BIRTH JAN. 24, 1881 | | 9. AGE (In years lost birthday) 84 | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME ALBERT ROBERTS | | 14. MOTHER'S MAIDEN NAME HEILORN LONG | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS MARY GLOVER - 307 DOLPHIN ST. | |
| 18. 421.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CHRONIC MYOCARDITIS. JANUARY 26 1964- DUE TO ARTERIOR SCLEROSIS JANUARY 26 1964 DUE TO CHRONIC MITRAL VALVE LEAK 1964. | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19. DATE OF OPERATION NONE | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE | | 20A. AUTOPSY? (Yes or No) NONE | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NONE | | 21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NONE | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NONE | | 21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21C. HOW DID INJURY OCCUR? | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from JANUARY 26 1964 to SEPTEMBER 13 1965 that (I) (we) last saw the deceased alive on SEPTEMBER 13 1965 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. yes. | | | | | |
| 23A. SIGNATURE <i>Charles Peter Clautice</i> M.D. 23C. PHYSICIAN'S NAME (Type) CHARLES PETER CLAUTICE | | | | 23B. DATE SIGNED SEPTEMBER 13 1965 | |
| 23D. ADDRESS 3013 SAINT PAUL STREET. | | SEPTEMBER 13 1965 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-16-65 | | 24C. NAME OF CEMETERY or CREMATORY NEW CATHEDRAL | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT. SEP 16 1965 | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Farley M.D.</i> | | 25C. FUNERAL DIRECTOR ADDRESS CHARLES R. LAW 802 MADISON AVE. | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9508 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9508 | |
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| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Henderson, Willie G. | | | | 2. DATE AND HOUR OF DEATH September 12, 1965 7:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 11-04 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital 1514 Division Street Baltimore, Maryland | | (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | D. STREET ADDRESS (If rural, give location) 1100 Madison Avenue | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH Nov. 15, 1897 | 9. AGE (In years last birthday) 67 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Newburg, S. C. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME James Henderson | | | | 14. MOTHER'S MAIDEN NAME Maggie Chapman | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mimms Funeral Home - Richmond, Va. | | | |
| 18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) CVA (cerebral hemorrhage) DUE TO (B) H.A.S.C.V.D. DUE TO (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from September 2, 1965 to September 12, 1965 , that (I) (we) last saw the deceased alive on September 12, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE  | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED September 12, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Andre Rigaud | | | | 23D. ADDRESS M.D. 1514 Division Street | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-16-65 | | 24C. NAME OF CEMETERY or CREMATORY Family Cemetery | | 24D. LOCATION (City, town, or county) (State) Chesterfield Co., Virginia | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 16 1965 | | 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR ADDRESS E. F. Mimms - 1827 Hull St., Richmond, Va. | | | |

FUNERAL DIRECTOR: IMPORTANT

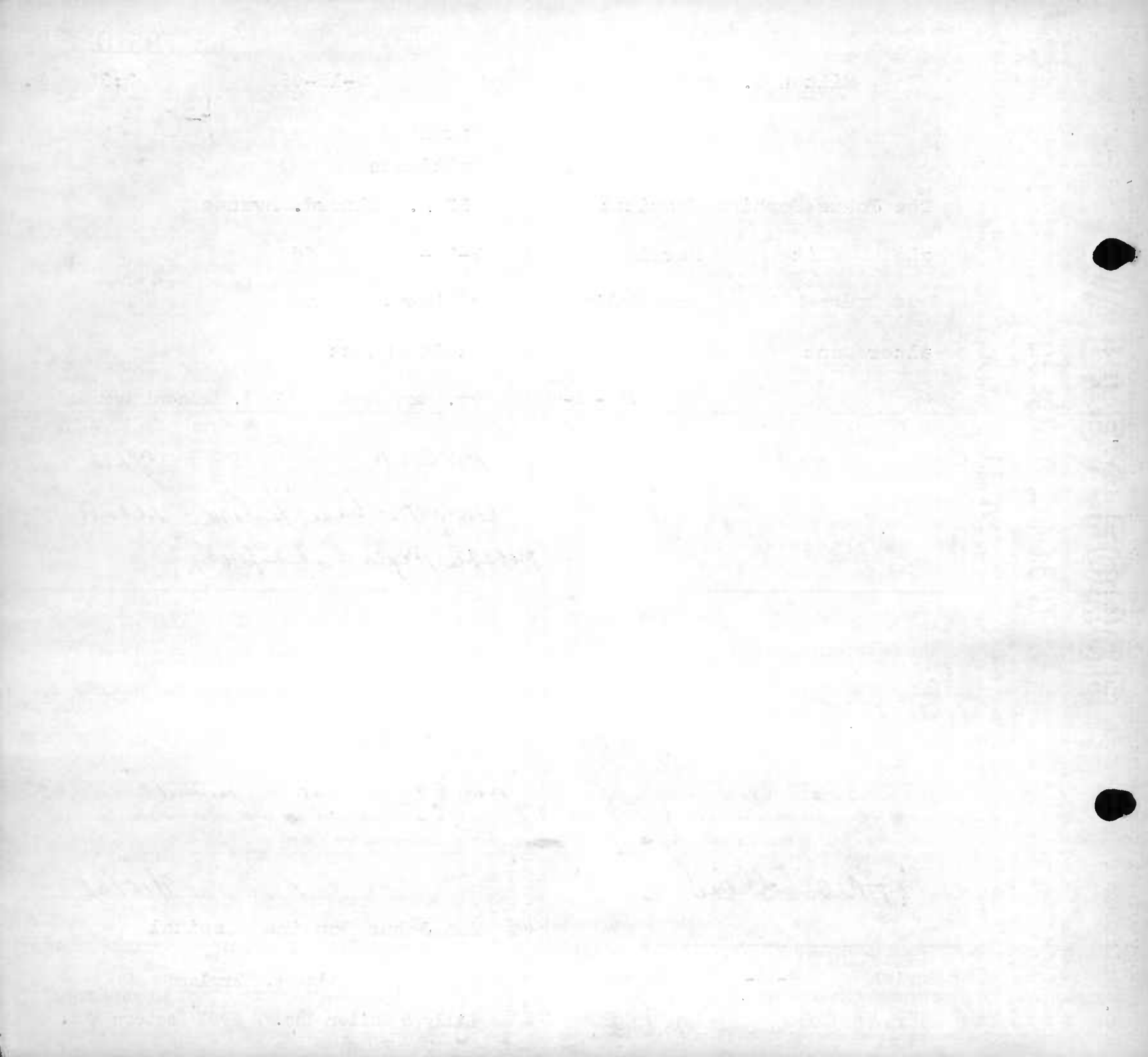
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9509 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9509 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MATILDA SMITH | | 2. DATE AND HOUR OF DEATH Sept. 14, 1965 2:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 15-04 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL 46 | | D. STREET ADDRESS (If rural, give location) 2002 N. BENTALOU ST. | | | |
| 5. SEX F | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 3/17/1894 | 9. AGE (In years last birthday) 71 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Frederick, Maryland | |
| 13. FATHER'S NAME Joseph Cooper | | 14. MOTHER'S MAIDEN NAME Mary ? | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT ADDRESS Earl Smith - 2002 N. Bentalou St. | |
| 18. 5-72-21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) SEVERE ANEMIA & ELECTROLYTE IMBALANCE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. CHRONIC ULCERATIVE COLITIS | | CAUSE OF DEATH SEVERE ANEMIA & ELECTROLYTE IMBALANCE (A) DUE TO CHRONIC ULCERATIVE COLITIS (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 7-9-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ULCERATIVE COLITIS | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <input type="checkbox"/> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input type="checkbox"/> | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from JUNE 17, 1965 to SEPT. 14, 1965 , that (I) (we) last saw the deceased alive on SEPT. 14, 1965 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Edoff G. de Poud | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-14-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS M.D. Lutheran Hosp. of Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9-18-65 | 24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park | | 24D. LOCATION (City, town or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 16 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS Charles R. Law 802 Madison Ave. | |

1
D-5330
The body of Milton Dent was released to the Johns Hopkins Hospital, Non-Med by Dr. Britnecker from the Medical Examiner's Office 9-15-65
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9510 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9510 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Milton C. Dent | | | 2. DATE AND HOUR OF DEATH 9-15-65 2:30 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Maryland B. COUNTY Baltimore | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 The Johns Hopkins Hospital | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) 532 S. Belnord. Avenue | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 7-20-09 | 9. AGE (In years last birthday) 56 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed | | 10B. KIND OF BUSINESS OR INDUSTRY Esso Station | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? | | | | | |
| 13. FATHER'S NAME Walter Dent | | | 14. MOTHER'S MAIDEN NAME Delia Barrett | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 217-32-9620 | | |
| 17. INFORMANT Mrs. Mary Dent | | | ADDRESS 532 S. Belnord Avenue | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) DUE TO ASCVD (B) DUE TO Congestive heart failure (C) probable myocardial infarction | | |
| INTERVAL BETWEEN ONSET AND DEATH years recent | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from May 27 1965 to June 17 1965, that (we) last saw the deceased alive on June 17 1965 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE [Signature] | | | 23B. DATE SIGNED 9/15/65 | | |
| 23C. PHYSICIAN'S NAME (Type) M.D. | | | 23D. ADDRESS The Johns Hopkins Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-18-1965 | | 24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery | |
| 24D. LOCATION Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 16 1965 | | 25B. NAME OF REGISTRAR Robert E. Finkbeiner | | 25C. FUNERAL DIRECTOR Lilly & Zeiler Inc. | |
| 25D. ADDRESS 1901 Eastern Ave. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
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| BIRTH NO. <u>65-28880</u> | | 65 9511 | | 65 9511 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>BABY BOY SIMONS</u> | | | 2. DATE AND HOUR OF DEATH <u>9-13-65</u> <u>10:45</u> A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u> <u>33rd CALVERT STS</u> <u>BALTIMORE 18</u> | | | A. STATE <u>MARYLAND</u> - <u>UNION MEMORIAL HOSP</u> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE 18</u> D. STREET ADDRESS (If rural, give location) <u>219 Glenrae Drive</u> | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u> | 8. DATE OF BIRTH <u>9-12-65</u> | 9. AGE (In years last birthday) <u>23</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. <u>23</u> <u>30</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>—</u> | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>7</u> | | | 14. MOTHER'S MAIDEN NAME <u>Annette D Simons</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS <u>219 Glenrae Drive</u> <u>chert</u> | | |
| 18. <u>7705T</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>frank</u> | | | CAUSE OF DEATH (A) <u>ATELECTASIS of lung</u> DUE TO (B) <u>Prematurity</u> DUE TO (C) <u>Erythoblastosis fetalis - (ABO)</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>23 hours</u> |
| 19A. DATE OF OPERATION <u>9-13-65</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from <u>9-12-65</u> to <u>9-13-65</u> , that (we) last saw the deceased alive on <u>9-13-65</u> and that in (my) opinion death occurred on the date and hour and from the causes stated above. (If (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Priscilla A. Gilman, MD</u> | | | | 23B. DATE SIGNED <u>9-13-65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>PRISCILLA A. GILMAN</u> | | 23D. ADDRESS <u>UNION MEMORIAL HOSPITAL</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <u>SEP 16 1965</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>JOHNS HOPKINS MEDICAL SCHOOL</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 16 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Finkbeiner</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>MORTUARY SERVICE - BCHD</u> | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>655 1593 B A 4</u> | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|-------------------------------------------------------------------------------------------|----------------------------------------------------------------------|
| BIRTH NO. <u>65-2188</u> <u>65</u> <u>9512</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Baby Linn Logan</u> | | 2. DATE AND HOUR OF DEATH <u>9/13/65</u> <u>12:20 p.m.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Lutheran Hospital of Maryland</u> | | A. STATE <u>Ma.</u> B. COUNTY <u>16-07</u> | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>3011 Belmont Avenue</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>C</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH <u>9/12/65</u> | 9. AGE (In years last birthday) <u>1</u> <u>9</u> <u>28</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>William A. Logan</u> | | | 14. MOTHER'S MAIDEN NAME <u>Annie R. McCray</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| 18. <u>773.51</u> | | CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO <u>Respiratory distress syndrome</u> | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO <u>prematurity</u> | | | |
| | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9/12/1965</u> to <u>9/13/1965</u> , that (I) (we) last saw the deceased alive on <u>9/13/1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Harold Lealphi</u> | | | | 23B. DATE SIGNED <u>9/13/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS M.D. <u>ANATOMY BOARD OF MARYLAND</u> <u>UNIVERSITY MEDICAL SCHOOL</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <u>SEP 14 1965</u> | | 24C. NAME of CEMETERY or CREMATORY <u>MORTUARY SERVICE - BCHD</u> | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 16 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Jackson</u> | |
| 25C. FUNERAL DIRECTOR | | 25D. ADDRESS | | | |

1. *Chamaea* *sp.*

Chamaea *sp.*

Chamaea *sp.*

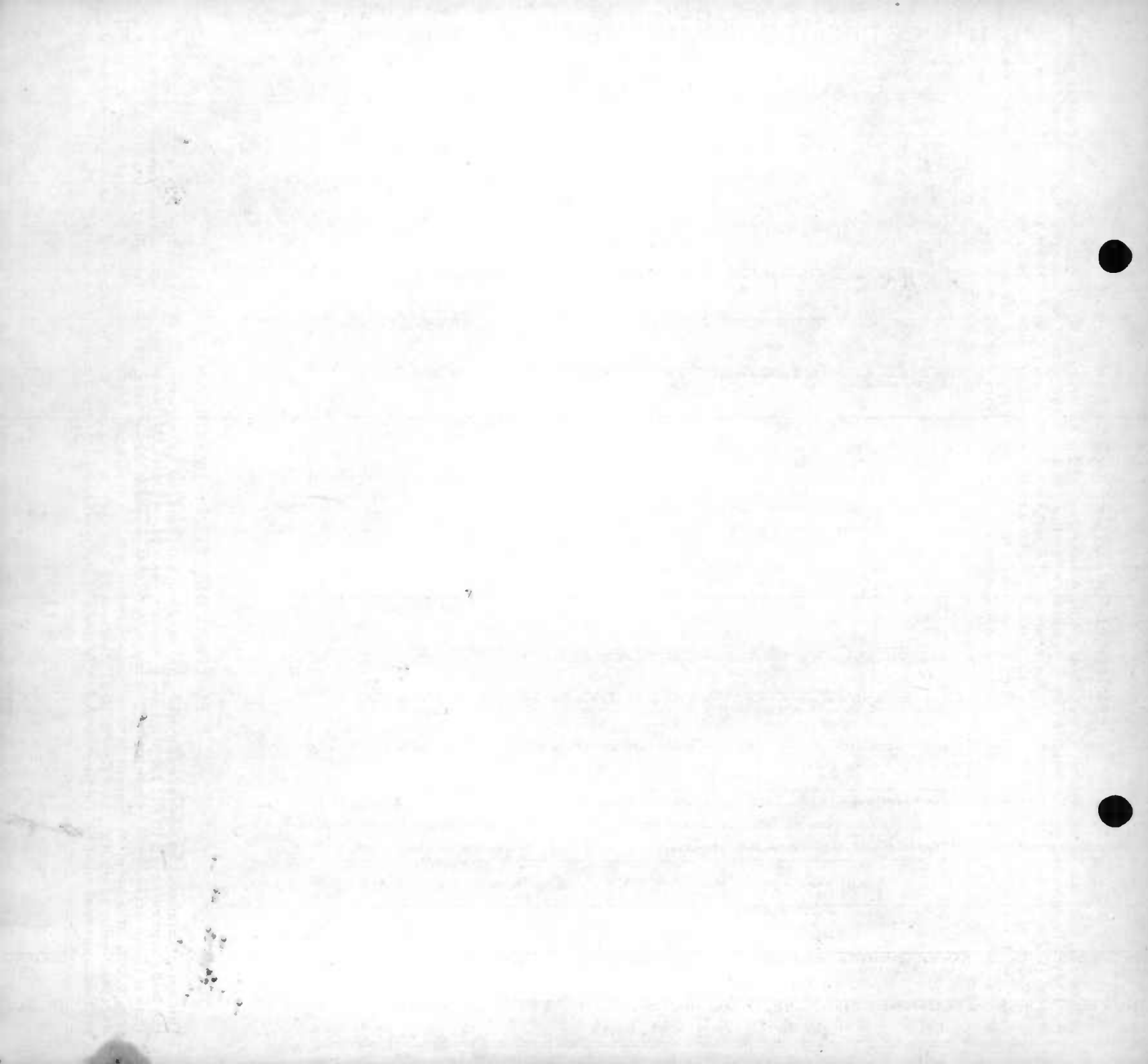
Chamaea *sp.*

Chamaea *sp.*

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|--------------------------------------------------------------------------|---------------------------------------------------------|
| BIRTH NO. 65-21717 65 9513 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9513 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Baby Girl Murphy | | 2. DATE AND HOUR OF DEATH 8-29-65 11 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital | | A. STATE Maryland B. COUNTY Balto | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 53-00 | | | |
| | | D. STREET ADDRESS (If rural, give location) 5514 Leland Ave - 2d. | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) S | 8. DATE OF BIRTH 8-29-65 | 9. AGE (In years lost birthday) 7 hours | If Under 1 Yr. Months: Days: Hours: Min. 7 15 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore | |
| 13. FATHER'S NAME David J. Murphy | | 14. MOTHER'S MAIDEN NAME Thelma L. Burton | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. 770.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Hemolytic disease of newborn ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-29 19 65 to 8-29 19 65 , that (I) (we) last saw the deceased alive on 8-29 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Perry S. Shelton | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 8-30-65 | |
| 23C. PHYSICIAN'S NAME (Type) Perry S. Shelton | | 23D. ADDRESS Mercy Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE SEP 3 1965 | | 24C. NAME OF CEMETERY OR CREMATORY ANATOMY BOARD OF MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 16 1965 | | 25B. NAME OF REGISTRAR Robert E. Fink | | 25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD | |
| | | 25D. ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. <u>65-21880</u> <u>65</u> <u>9514</u> | | | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. <u>65</u> <u>9514</u> <u>7</u> | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------|------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|----------------------------------------------------------------------|--|
| 1. NAME OF DECEASED (Type or Print) <u>Baby Boy LOGAN</u> | | | | 2. DATE AND HOUR OF DEATH <u>9/12/65</u> <u>10 P.M.</u> | | | |
| 3. PLACE OF DEATH IN <u>BALTIMORE, MARYLAND</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>16-07</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Lutheran Hospital of Maryland</u> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <u>3011 Belmont Avenue</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>C</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH <u>9/12/65</u> | 9. AGE (In years lost birthday) <u>-</u> <u>-</u> <u>19</u> <u>8</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>William A. Logan</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Annie R. McCray</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| 18. <u>773.51</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | (A) DUE TO <u>Respiratory distress syndrome</u> | | | |
| | | (B) DUE TO <u>prematurity</u> | | | | | |
| | | (C) _____ | | | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9/12</u> <u>1965</u> to <u>9/12</u> <u>1965</u> , that (I) (we) last saw the deceased alive on <u>9/12</u> <u>1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Hossein Calisher</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>9/12/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 16 1965</u> | | | | 25B. NAME OF REGISTRAR <u>Robert E. Fairbank</u> | | 25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHO</u> | |

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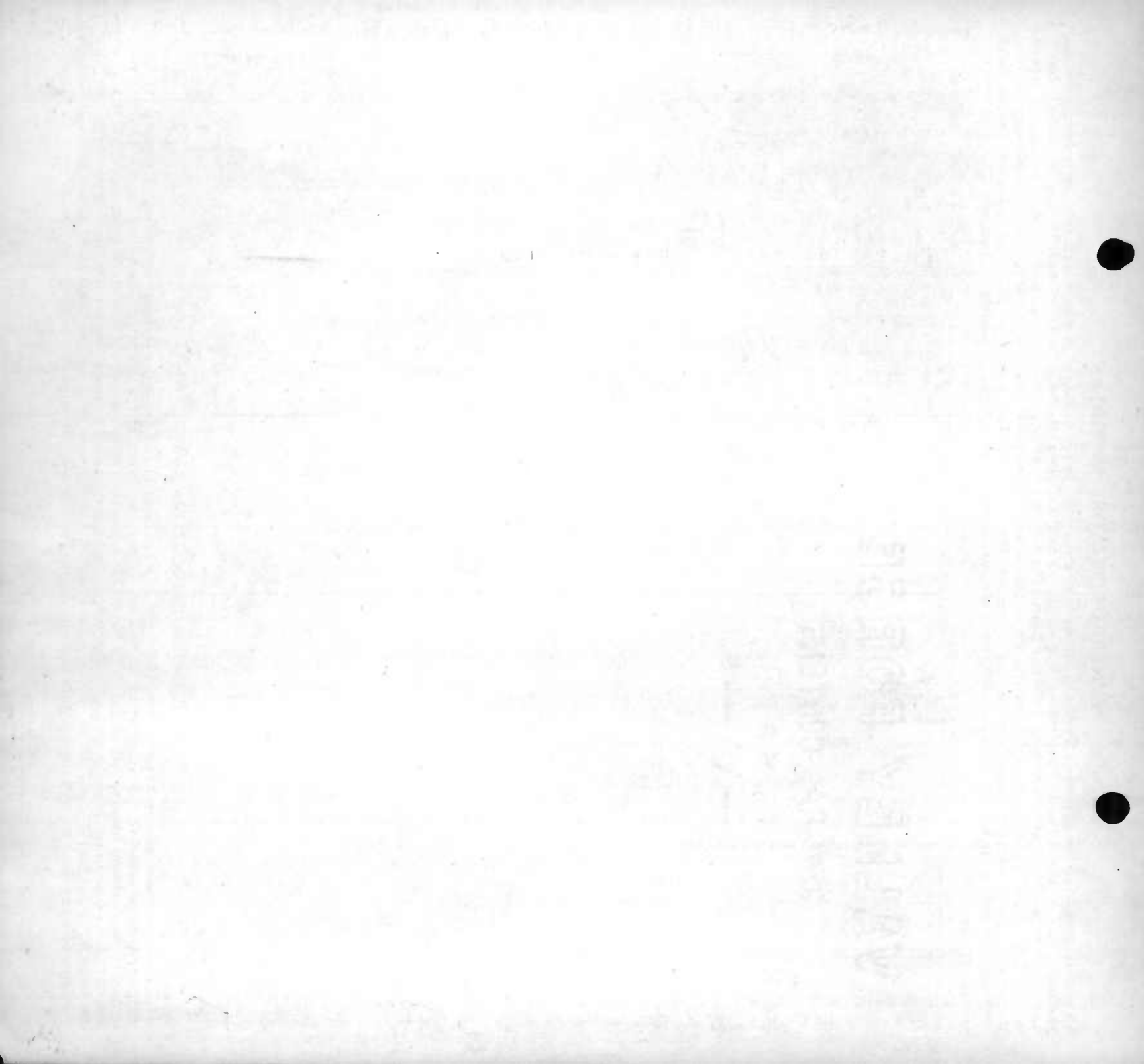
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

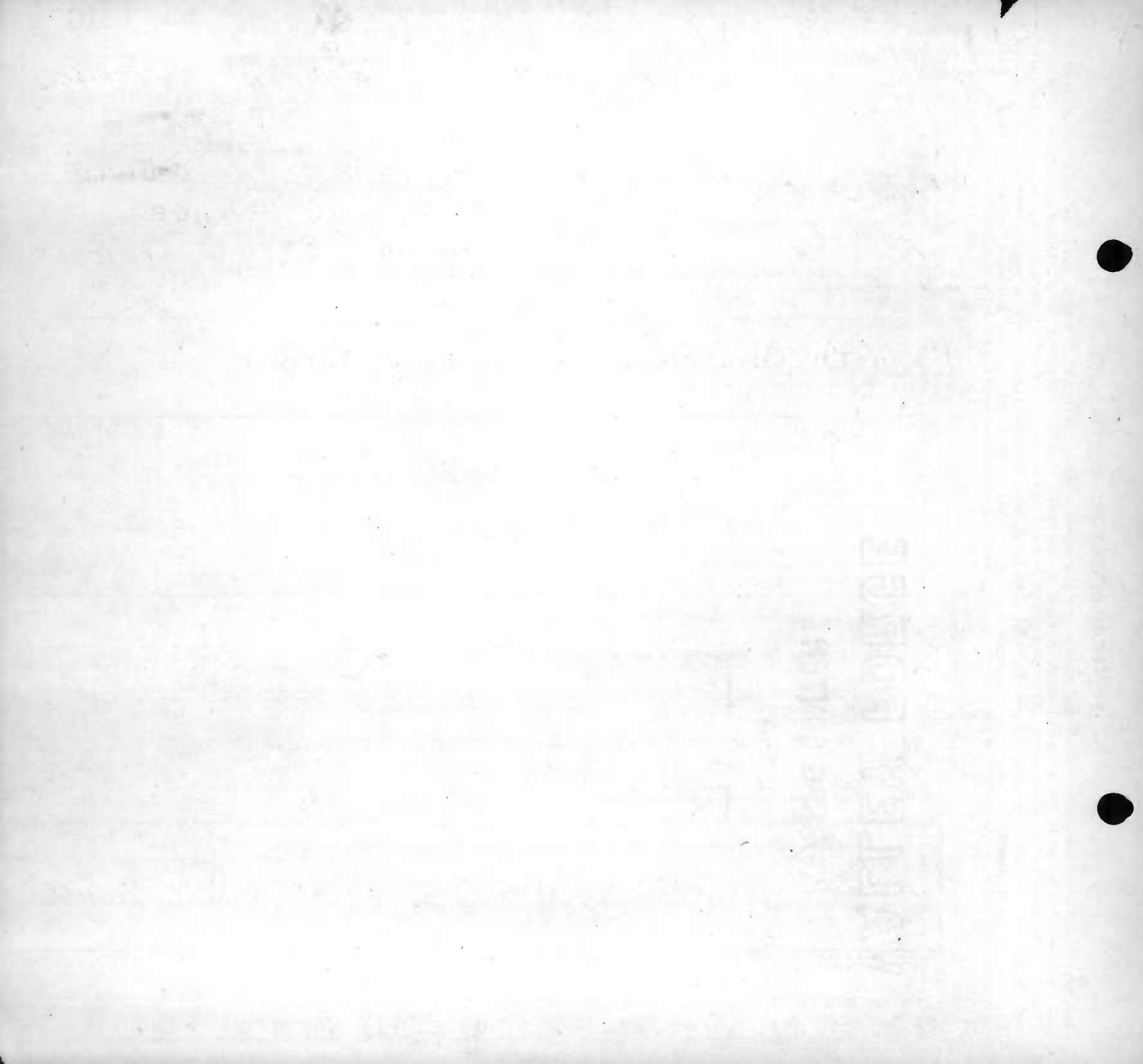
| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. <u>65-23122</u> <u>65</u> <u>9515</u> | | CERTIFICATE OF DEATH | | Registered No. <u>65</u> <u>9515</u> <u>4</u> | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|-------------------------------------------------------------|--|
| 1. NAME OF DECEASED (Type or Print) <u>Thames, Jacob William</u> | | | | 2. DATE AND HOUR OF DEATH <u>9/6/65</u> <u>9:20</u> P.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Johns Hopkins Hospital</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>8-02</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1811 N. Duncan St.</u> | | | | | |
| 5. SEX <u>Male</u> | | 6. RACE <u>Negro</u> | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u> | | 8. DATE OF BIRTH <u>9/4/65</u> | | 9. AGE (In years lost birthday) <u>32</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Samuel Thames</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mildred Wilson</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT ADDRESS | | | |
| 18. <u>773.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) <u>Hyaline Membrane Disease</u> DUE TO (B) _____ DUE TO (C) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Birth to 53 hrs.</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9/4</u> <u>1965</u> to <u>9/6</u> <u>1965</u> , that (I) (we) lost saw the deceased alive on <u>9/6</u> <u>1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>Herbert Kaizer</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>9/6/65</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Herbert Kaizer</u> | | | | 23D. ADDRESS M.D. <u>Johns Hopkins Hospital</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 16 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>8020</u> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

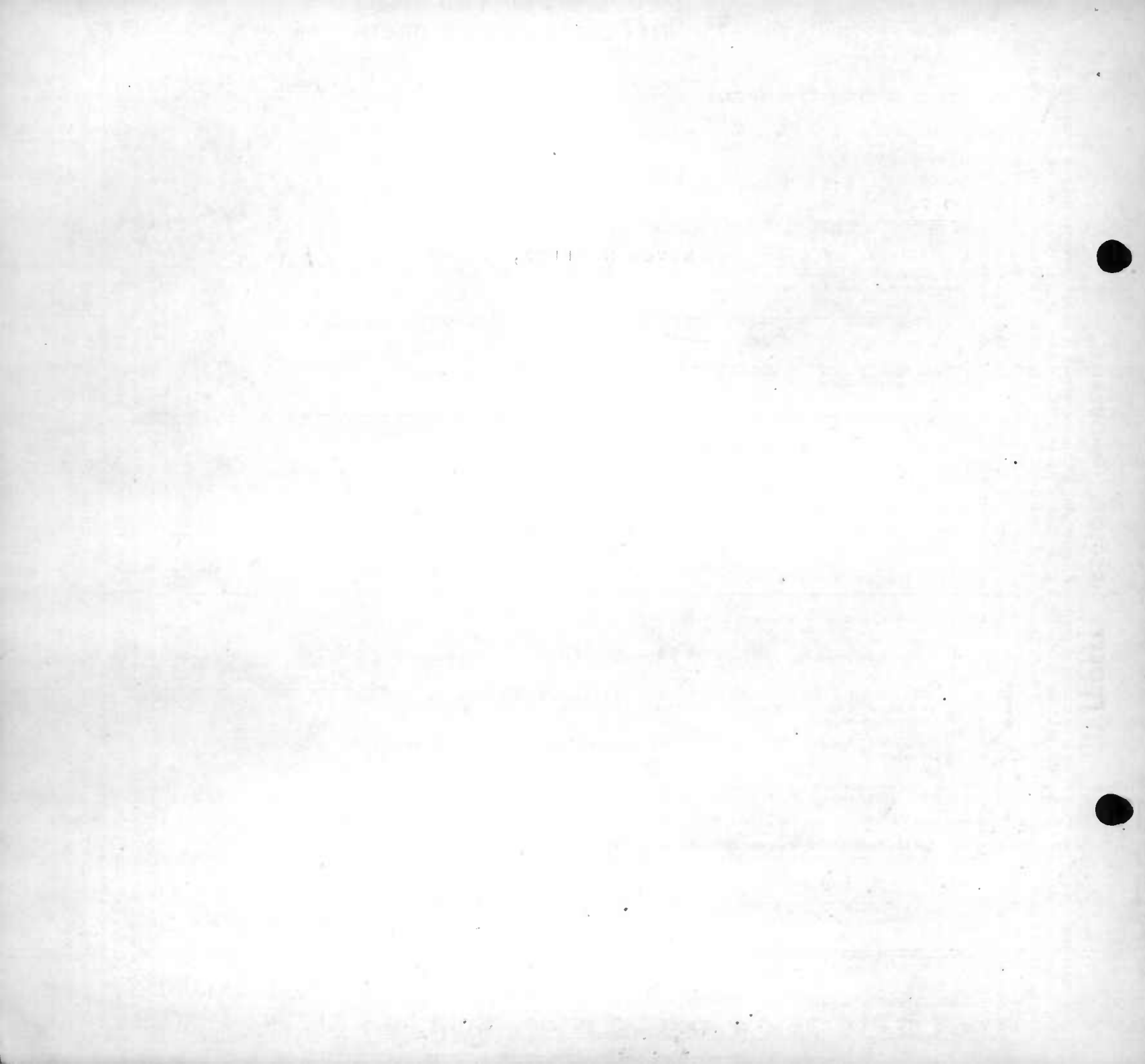
| | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-----------------------|----------------------------------------------------------------------|-----------------------|
| BIRTH NO. 65 22643 | | 65 9516 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9516 | |
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Baby Girl PARKER</i> | | | | 2. DATE AND HOUR OF DEATH <i>9/13/65 9:45 A.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Lutheran Hospital of Maryland</i> | | | | A. STATE <i>Md.</i> B. COUNTY <i>Balto</i> | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Arbutus #27</i> | | | | D. STREET ADDRESS (If rural, give location) <i>2515 Gehl Avenue</i> | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH <i>9/11/65</i> | 9. AGE (In years lost birthday) | If Under 1 Yr. Months | If Under 24 Hrs. Days | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | |
| 13. FATHER'S NAME <i>Kenneth Clawson</i> | | | 14. MOTHER'S MAIDEN NAME <i>Grace Parker</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | 17. INFORMANT | | ADDRESS | |
| 18. <i>776X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) <i>I Mand Tunity</i> DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? <i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9/11/1965</i> to <i>9/13/1965</i> , that (I) (we) last saw the deceased alive on <i>9/13/1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Hossein Deapine</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>9/13/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <i>SEP 14 1965</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>ANATOMY BOARD OF MARYLAND</i> | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 16 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Fager</i> | | 25C. FUNERAL DIRECTOR <i>MORTUARY SERVICE - BCHD</i> | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|-----------------------------------|----------------------------------------------------|--|
| BIRTH NO. <u>65-21481 65</u> | | 9517 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>65</u> | | 9517 | |
| M.E. CASE NO. | | | | | 1. NAME OF DECEASED (Type or Print) <u>Payton, Anthony Russell</u> | | | | |
| 2. DATE AND HOUR OF DEATH <u>9/6/65</u> | | | | | <u>1 7 00 PM</u> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Johns Hopkins Hospital</u> <u>33</u> | | | | | A. STATE <u>MD.</u> B. COUNTY <u>13-04</u> | | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | | | D. STREET ADDRESS (If rural, give location) <u>2313 Avalon Ave</u> | | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>Negro</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u> | | 8. DATE OF BIRTH <u>8-26-65</u> | 9. AGE (In years, /, last birthday) <u>12 days</u> | If Under 1 Yr. Months Days Hours Min. <u>11</u> | | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>Anthony Payton</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Jacqueline</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | | ADDRESS | | |
| 18. <u>776X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) <u>Prematurity</u> DUE TO (B) _____ DUE TO (C) _____ | | | INTERVAL BETWEEN ONSET AND DEATH <u>11 days</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Birth 8/26</u> 19 <u>65</u> to <u>9/6</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>9/6</u> 19 <u>65</u> and that in (my) (our) applan death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>Herbert Kaizer</u> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>9/6/65</u> | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Herbert KAIZER</u> | | | | | 23D. ADDRESS <u>Johns Hopkins Hospital</u> <u>ANATOMY BOARD OF MARYLAND</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <u>SEP 14 1965</u> | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 16 1965</u> | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | |
| MORTUARY SERVICE - BCHD | | | | | | | | | |



1
5-156

65 9518

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 9518

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) **ALONZA D. SPINNER** 2. DATE AND HOUR PRONOUNCED DEAD **August 22, 1965** **6:07 P. M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE **Maryland** B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**

D. STREET ADDRESS (If rural, give location) **699 W. Baltimore St.**

5. SEX **Male** 6. RACE **Negro** 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH 9. AGE (In years last birthday) **53** If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS

18. **443X I** CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) **Hypertensive Cardiovascular Disease**

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) **Yes** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? **Yes**

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: **Natural causes** ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Russell S. Fisher, M.D.** CHIEF MEDICAL EXAMINER ☒ DATE SIGNED **8/23/65**

EXAMINER'S NAME (Type) **Russell S. Fisher, M.D.** ASSISTANT MEDICAL EXAMINER ☐ ASSOCIATE MEDICAL EXAMINER ☐

23A. BURIAL CREMATION, REMOVAL (Specify) 23B. DATE **SEP 10 1965** 23C. NAME OF CEMETERY or CREMATORY **ANATOMY BOARD OF MARYLAND** 23D. LOCATION **City, town, or county** (State)

24A. DATE REC'D BY HEALTH DEPT. **SEP 16 1965** 24B. NAME OF REGISTRAR **Robert E. Fisher, M.D.** 24C. FUNERAL DIRECTOR **MORTUARY SERVICE - BCHD** ADDRESS

VS 151-REV. 1/1/65 19650000031

WALLING FORG

NO CONTENT

REPRODUCTION (Part) (Part) on (Part)

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Jan

Walling J. Walling

BIRTH NO.

65

9519

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 9519

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ANN

HARMON

2. DATE AND HOUR PRONOUNCED DEAD

August 25, 1965

7:40 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

312 W. Camden Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (in years
last birthday)

70

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic Heart Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

8/26/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

SEP 10 1965

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 16 1965

Robert E. Farley

MORTUARY SERVICE - BCHD

VALLEY FOLIO

VALLEY FOLIO

BIRTH NO. 65 9520 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 9520

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print) **KATIE LOWERY** 2. DATE AND HOUR PRONOUNCED DEAD
September 2, 1965 10:10 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

302 N. Pearl Street4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland** B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

302 N. Pearl Street

5. SEX

Female

6. RACE

Negro7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)**55**If Under 1 Yr. II Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) **Arteriosclerotic Heart Disease.**
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO(C)
DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/2/6523A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

SEP 10 1965

23C. NAME OF CEMETERY OR CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 16 1965Robert E. Farley, M.D.**MORTUARY SERVICE - BCHD**

US20

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

PETER ADOLPH MOLLING, M.D.

2. DATE AND HOUR PRONOUNCED DEAD

September 7, 1965 12:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1004 W. Lake Avenue

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
lost birthday)

41

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown. If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18. E974X

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Asphyxia
DUE TO hanging

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

office

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Rm. T-605 Psychiatric Clinic - Univ. Hosp

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

9

7

65

?

m.

21E. INJURY OCCURRED

WHILE AT
WORK

X

NOT WHILE
AT WORK

□

21F. HOW DID INJURY OCCUR?

hung self

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/8/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

SEP 16 1965

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

SEP 16 1965

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

UNIVERSITY MEDICAL SCHOOL

MORTUARY SERVICE - BCHD

VALLEY FORGE

440-00124

29A

BIRTH NO.

65 9522

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JOSEPH

BIEN

2. DATE AND HOUR PRONOUNCED DEAD

September 2, 1965

3:35 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

525 N. Charles Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osthenia, etc. It means the disease,
injury or complication which caused death.)(A) Gunshot Wound of Head.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

525 N. Charles Street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
9 2 '65 A

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Shot self in head.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/3/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION (City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

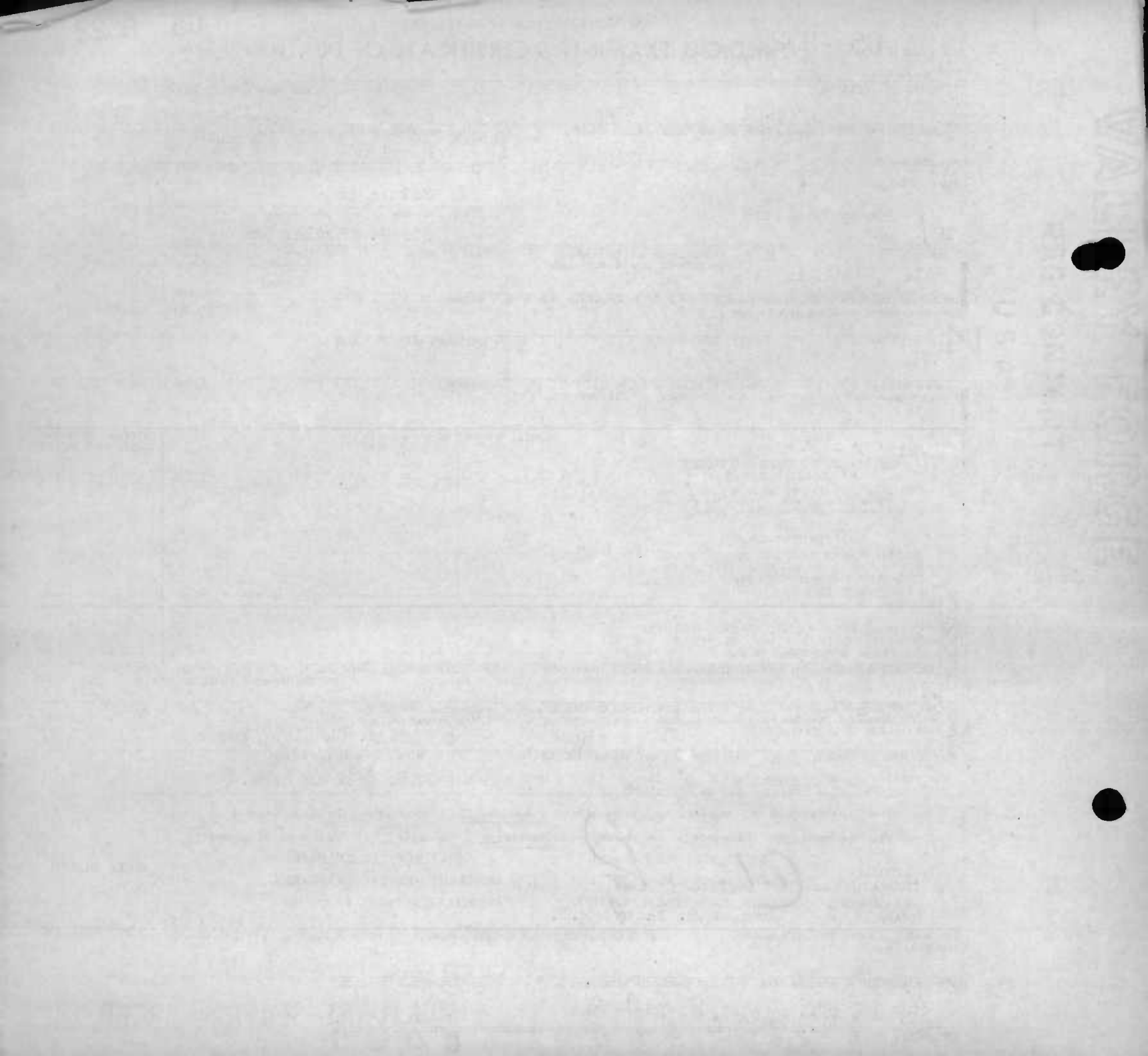
24C. FUNERAL DIRECTOR

ADDRESS

SEP 16 1965

Robert E. Fajardo

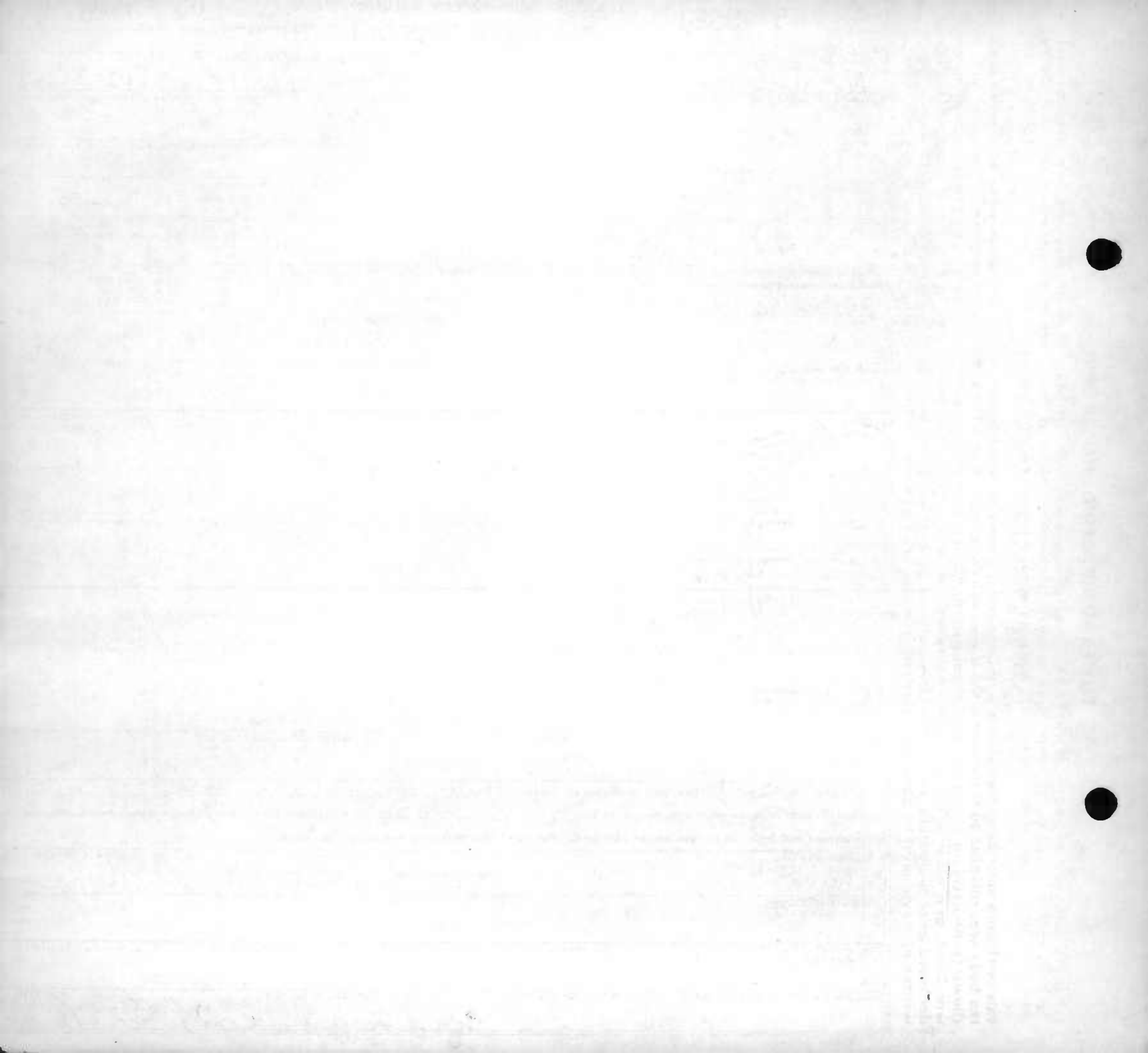
MORTUARY SERVICE - BCHD



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. | | 65 9523 | | 65 9523 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) MATHIAS, MARK N. | | | 2. DATE AND HOUR OF DEATH Sept. 14, 1965 12:35 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 91 KESWICK | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | |
| | | | D. STREET ADDRESS (If rural, give location) 6313 E. ELINORE AVE. 21206 | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 11-19-77 | 9. AGE (In years last birthday) 87 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FINISHER-ROLLING MILL | | 10B. KIND OF BUSINESS OR INDUSTRY BETHLEHEM STEEL CO. | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME RUBEN J. MATHIAS | | | 14. MOTHER'S MAIDEN NAME EMMA SONACKER | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 213-07-4452 | | 17. INFORMANT Heleen E. Leau, T. N. | |
| 18. 331X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Acute Respiratory Infection DUE TO (B) Cerebro-Vascular Accident DUE TO (C) Arteriosclerosis | | | INTERVAL BETWEEN ONSET AND DEATH 36 hrs 5 1/2 days 4 1/2 yrs. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9 March 1965 to 14 Sept 1965 , that (I) (we) last saw the deceased alive on 14 Sept 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Aubrey D. Richardson | | | | 23B. DATE SIGNED 14 Sept 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Aubrey D. Richardson | | | | 23D. ADDRESS M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/16/1965 | | 24C. NAME of CEMETERY or CREMATORY Church of God Cemetery | |
| 24D. LOCATION (City, town, or county) Union Town, Maryland | | 24E. LOCATION (State) Maryland | | 24F. LOCATION (Country) U.S.A. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 16 1965 | | 25B. NAME OF REGISTRAR Robert E. Fairbank | | 25C. FUNERAL DIRECTOR Wm. J. Fairbank & Sons | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9524 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9524 | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------|---------------------------------|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) HAMILTON, MARIE MARIE | | | |
| 2. DATE AND HOUR OF DEATH 9/15/65 12¹⁵ P.M. | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 37 MERCY HOSP., INC. | | | | A. STATE MARYLAND B. COUNTY 15-DC | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | | D. STREET ADDRESS (If rural, give location) 3024 West North Avenue 21213 | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W | 8. DATE OF BIRTH 9/14/97 | 9. AGE (In years last birthday) 68 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME JOHN P. SEABOLD | | | | 14. MOTHER'S MAIDEN NAME EMMA ROSEN STEEL | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS 8405 Liberty Road Baltimore, Md. 7 | | | |
| 18. 1334 I CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO Bronchopneumonia | | 4/week | |
| ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause, (A) stating the UNDERLYING CONDITION last.) | | | | (B) DUE TO Massive necrosis of Rt. lung & hemorrhage & debilitation | | 6 wks. | |
| | | | | (C) Thrombosis of mesenteric vessels | | 6 wks. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. E pleural effusion & ascites | | | | | | | |
| 19A. DATE OF OPERATION 2 NONE | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NONE | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) YES | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) NONE | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept. 7, 1965 to Sept. 15, 1965 , that (I) (we) last saw the deceased alive on Sept. 15, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Patrick F. Dougherty, Jr. M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 9/15/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) Mary Hosp. M.D. | | | | 23D. ADDRESS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/18/1965 | | 24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 16 1965 | | 25B. NAME OF REGISTRAR Robert E. Fagan | | 25C. FUNERAL DIRECTOR Wm. J. Fickner & Sons | | ADDRESS 1700 North Peavee | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | Registered No. | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|----------------------------------------------|---------------------------------------------------------------------------------------------|--|
| 65 9525 | | | | | | 65 9525 | |
| BIRTH NO. 65 9525 | | | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | | | 2 | |
| 1. NAME OF DECEASED (Type or Print) <i>Thornhill Lawrence Mabe</i> | | | | | | 2. DATE AND HOUR OF DEATH <i>9-15-65 12 M.N.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Union Memorial Hospital 44</i> | | | | | | A. STATE <i>Maryland</i> B. COUNTY <i>27-05</i> | |
| | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | |
| | | | | | | D. STREET ADDRESS (If rural, give location) <i>3226 Northern Pkwy 14</i> | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i> | | 8. DATE OF BIRTH <i>12-18-22</i> | 9. AGE (In years last birthday) <i>42</i> | If Under 1 Yr. If Under 24 Hrs. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machinist</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Londontown Mfg. Co.</i> | | 11. BIRTHPLACE (State or foreign country) <i>Virginia</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Wm. Mabe</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Ocie Parker</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes World War II</i> | | 16. SOCIAL SECURITY NO. <i>227-14-2583</i> | | 17. INFORMANT <i>Mrs. Emmalene R. Mabe</i> | | ADDRESS <i>3226 Northern Pkwy. Baltimore, Md. 14</i> | |
| 18. CAUSE OF DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Cirrhosis</i> | | | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Uremia</i> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <i>9-8-65</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9-15-65</i> to <i>9-15-65</i> , that (I) (we) last saw the deceased alive on <i>9-15-65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Hudson Fesche</i> M.D. | | | | | | 23B. DATE SIGNED <i>9-15-65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>PAUL HUDSON FESCHE Hudson Fesche</i> M.D. | | | | 23D. ADDRESS <i>UNION MEMORIAL HOSPITAL</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>9/20/1965</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Baltimore National Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 16 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Fesche</i> | | 25C. FUNERAL DIRECTOR <i>Wm. J. Jackson & Son</i> ADDRESS <i>Balt. Md. 17 North 1st Ave.</i> | | | |

PAUL WESCH WESCH

PAUL WESCH WESCH

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9526 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9526 | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------|------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|------------------------------------------------------------------------|-----------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) MARION P. McCOMAS | | | | 2. DATE AND HOUR OF DEATH 15 SEPT. 1965 3:55 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL 48 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE MARYLAND B. COUNTY 27-38 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE #14 D. STREET ADDRESS (If rural, give location) 5802 WILLOWTON AVENUE | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH Jan. 29, 1894 | 9. AGE (In years last birthday) 71 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Accountant | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JAMES B. McCOMAS | | | | 14. MOTHER'S MAIDEN NAME MOLLIE E. PENNINGTON | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 216-10-4316 | | 17. INFORMANT Mrs. Mary W. McComas | | ADDRESS (Same) | |
| 18. 154X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH (A) ADENOCARCINOMA OF RECTUM DUE TO 2 METASTASES (B) _____ DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 24 August 1965 to 15 September 1965 , that (I) (we) last saw the deceased alive on 14 September 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Donald M. Barrick | | | | M.D. Attending <input type="checkbox"/> Phys. Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/15/65 | |
| 23C. PHYSICIAN'S NAME (Type) Donald M. Barrick | | | | 23D. ADDRESS M.D. MARYLAND GENERAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/18/65 | | 24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 16 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214 | | | |

Thomas F. MacCann

James E. MacCann

James E. MacCann

James E. MacCann

James E. MacCann

James E. MacCann

James E. MacCann

James E. MacCann

James E. MacCann

James E. MacCann

No

James E. MacCann

No

James E. MacCann

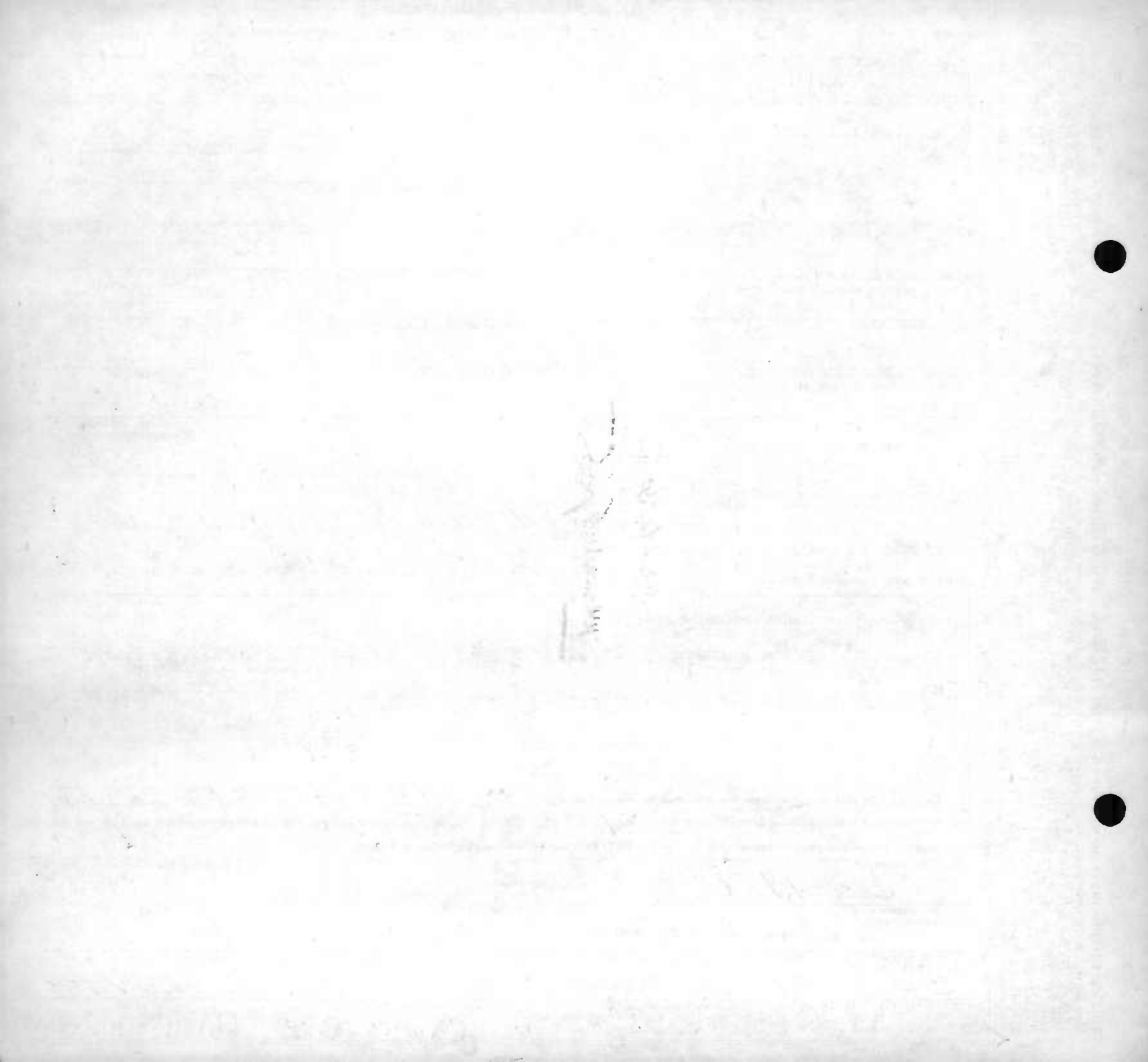
James E. MacCann

James E. MacCann

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

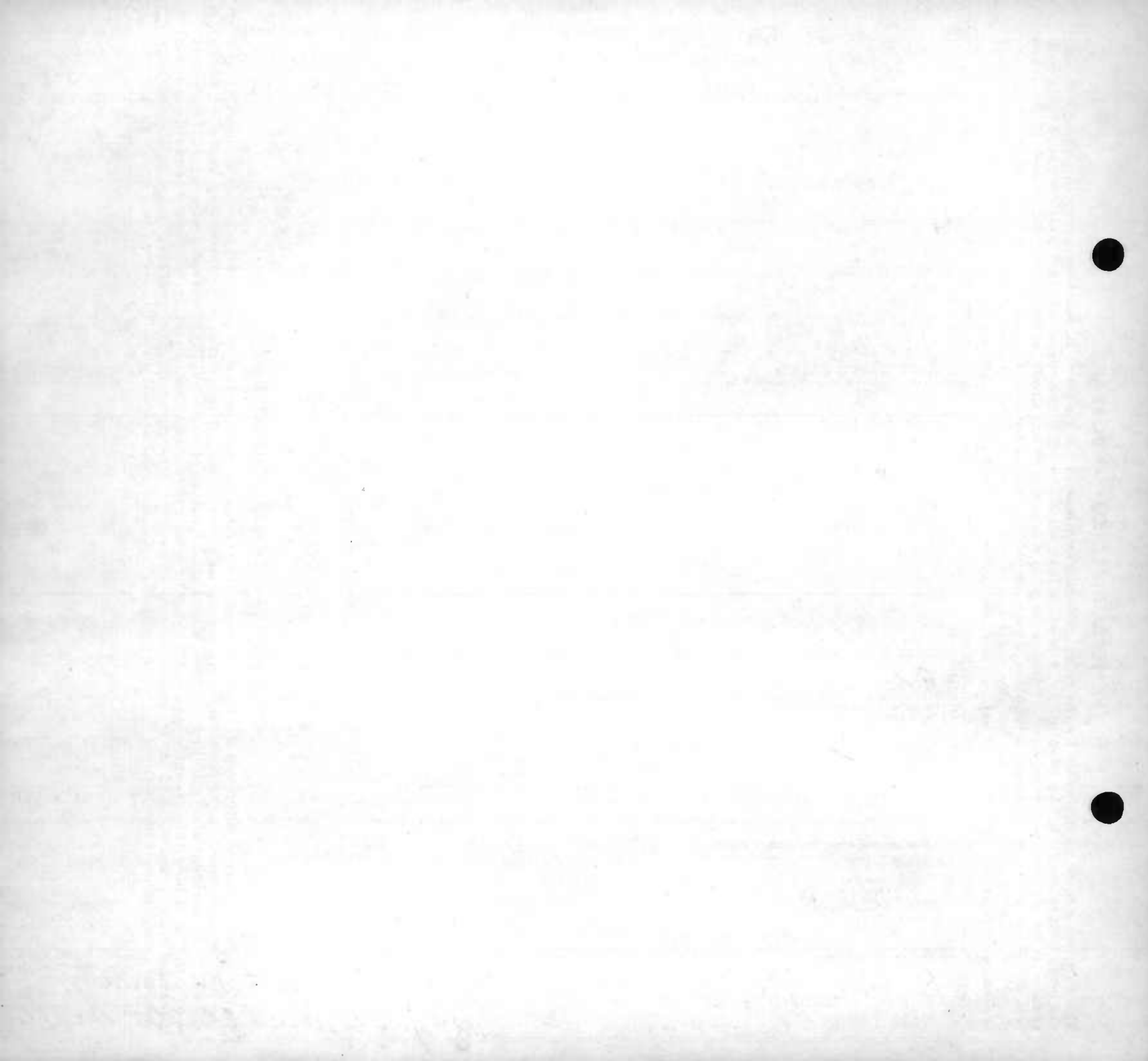
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-----------------------------------------------------|--|
| BIRTH NO. 65 9527 | | CERTIFICATE OF DEATH | | | | Registered No. 65 9527 | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) William R. Lyles | | | | 2. DATE AND HOUR OF DEATH 9-15-65 2:40 M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 34 Bon Secours Hospital | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY BALTIMORE Co. | | | |
| 5. SEX M | | 6. RACE Colored | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married | | 8. DATE OF BIRTH 6-9-21 | | 9. AGE (In years last birthday) 44 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY Unemployed | | 11. BIRTHPLACE (State or foreign country) Virginia | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Oscar Lyles | | | | | | 14. MOTHER'S MAIDEN NAME Leslie Pryor | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT 9 Lee Avenue 1838 W. Baltimore St | | | ADDRESS | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | CAUSE OF DEATH acute myocardial infarction arteriosclerotic Ht. Disease generalized arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH 2 days years | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept. 13 1965 to Sept 15 1965, that (I) (we) last saw the deceased alive on Sept 15 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Juan F. Sordo | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Sept 15, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) JUAN F SORDO | | | | | | 23D. ADDRESS Bon Secours Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/19/65 | | 24C. NAME OF CEMETERY or CREMATORY Farmville | | 24D. LOCATION (City, town, or county) (State) Farmville, VA. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 16 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Charles Rice | | ADDRESS 661 W. Barrage Rice | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

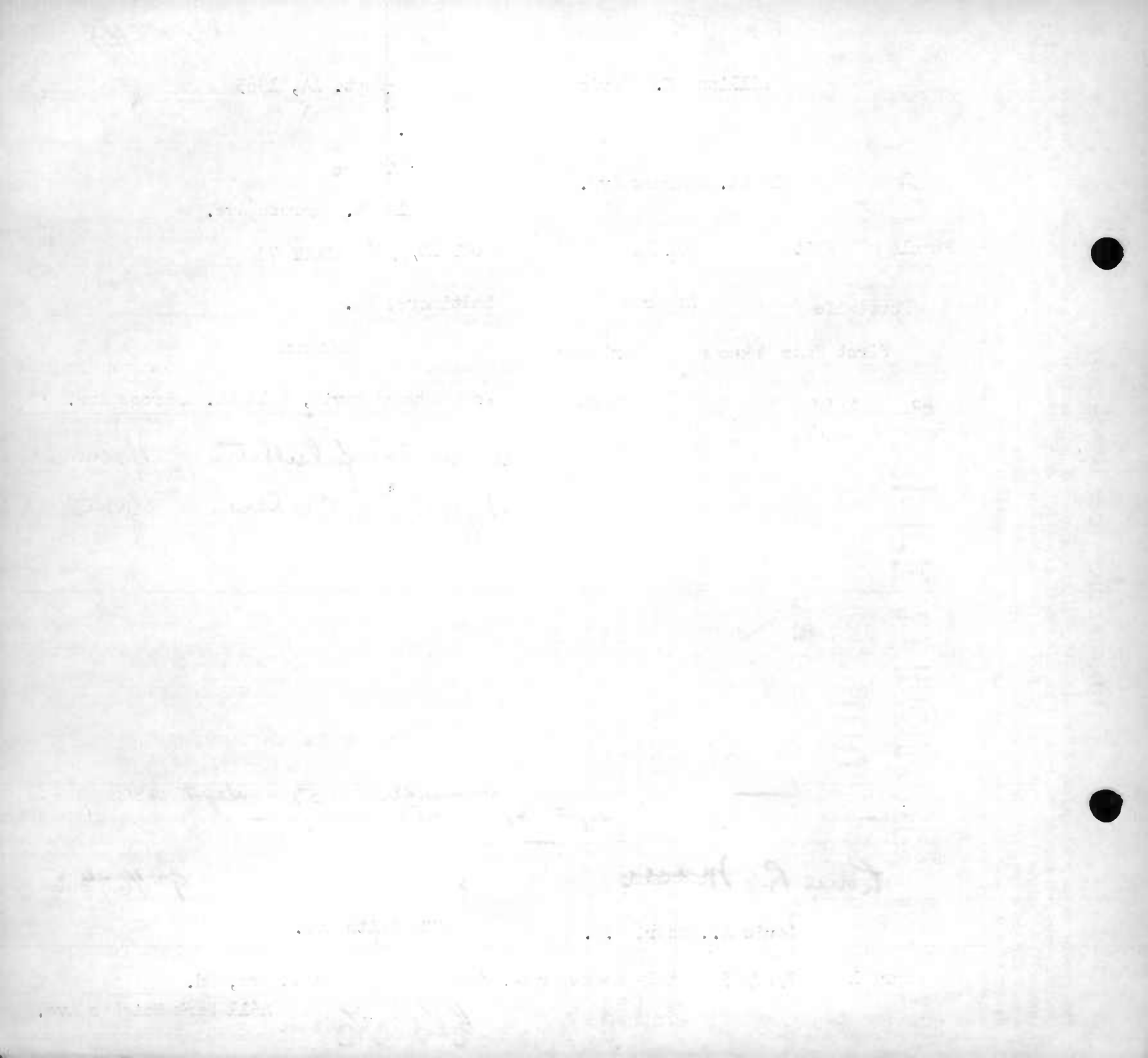
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------|--|---------------------------------------------------------------------------------------------------|----------------------|--------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|--------------------------------------|--|------------------------------------------|--|
| BIRTH NO. 65-22945 65 9528 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 9528 | | | | | |
| M.E. CASE NO. | | | | | | | | | | 2. DATE AND HOUR OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) Baby Boy Riggsbee | | | | | | | | | | 9-14-65 1 8 P M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 University Hospital | | | | | | | | | | A. STATE Maryland B. COUNTY 15-32 | | | | | |
| | | | | | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | | | |
| | | | | | | | | | | D. STREET ADDRESS (If rural, give location) 3100 Piedmont Ave. | | | | | |
| 5. SEX Male | | 6. RACE Negro | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH 9-13-65 | | 9. AGE (In years last birthday) 1 | | 10. Under 1 Yr. Months Days | | 11. Under 24 Hrs. Hours Min. 19 min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME Paul A. Riggsbee | | | | | | | | 14. MOTHER'S MAIDEN NAME Margaret Johnson | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS CHART | | | | | |
| 18. 773.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | | | | | | | CAUSE OF DEATH (A) Respiratory Distress DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH 24 hrs. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | (B) DUE TO | | | | | |
| | | | | | | | | | | (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION 2 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | | | 21E. INJURY OCCURRED White At <input type="checkbox"/> Nat White At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-13-1965 to 9-14-1965, that (I) (we) lost saw the deceased alive on 9-14-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 23A. SIGNATURE Earle H. Francis M.D. | | | | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9-14-65 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) Earle H. Francis M.D. | | | | | | | | 23D. ADDRESS University Hospital | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 9/16/65 | | 24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery | | | | 24D. LOCATION (City, town, or county) (State) Westport (Baltimore) and | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 16 1965 | | | | 25B. NAME OF REGISTRAR Robert E. Fasham | | | | 25C. FUNERAL DIRECTOR ADDRESS Joseph L. Rios 2222 W. North Ave. Baltimore, Md. | | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

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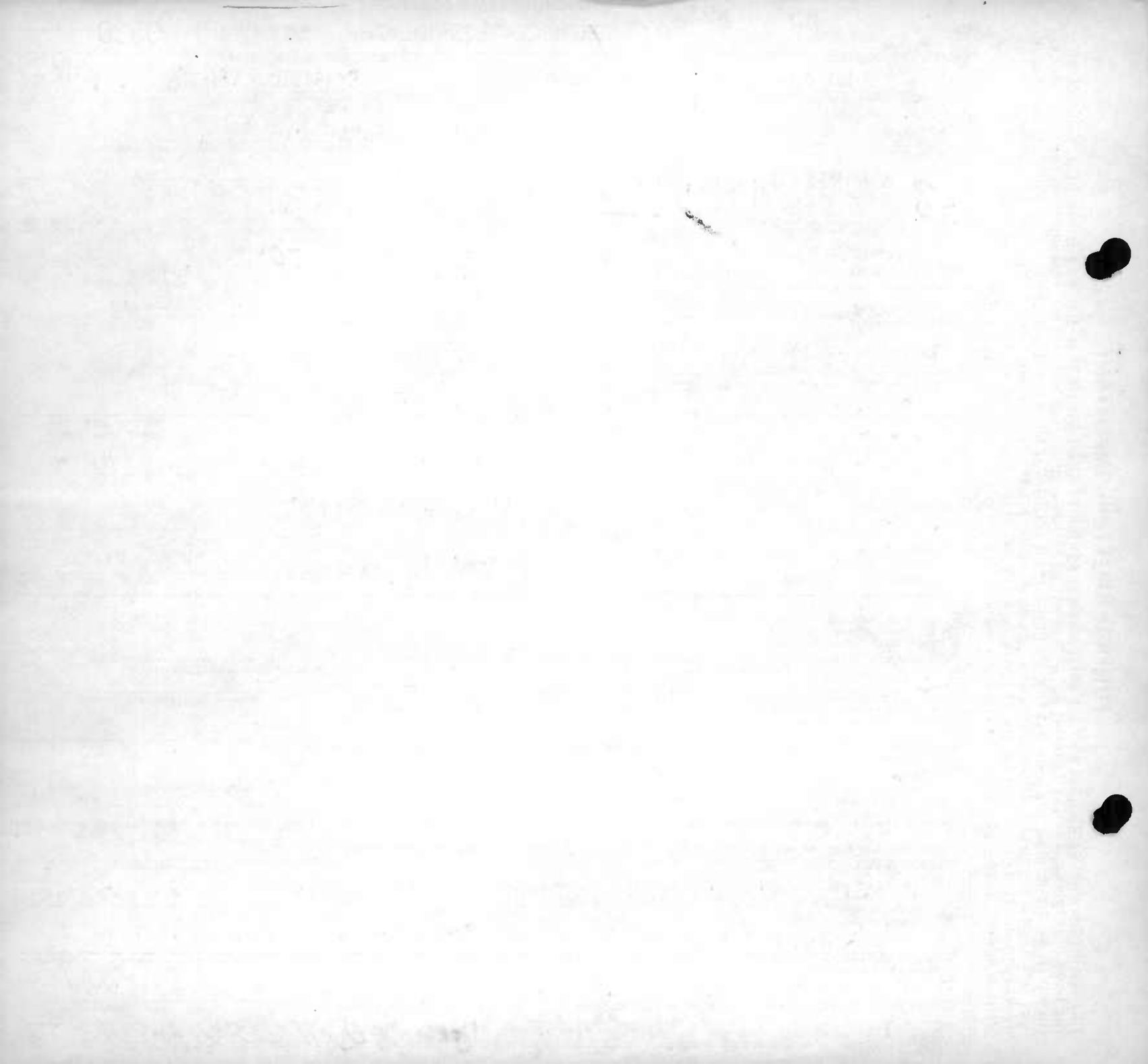
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------|----------------------------------------------------|--|
| BIRTH NO. 65 9529 | | CERTIFICATE OF DEATH | | | | Registered No. 65 9529 | | | |
| 1. NAME OF DECEASED (Type or Print) Lillian K. Bavis | | | | | 2. DATE AND HOUR OF DEATH Sept. 14, 1965 | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3418 St. Ambrose Ave. | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 27-16 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3418 St. Ambrose Ave. | | | | |
| 5. SEX Female | | 6. RACE White | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH ABOUT 10/5/86 | | 9. AGE (In years lost birthday) ABOUT 78 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME First Name Unknown Krieger | | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT John Edward Bavis, 3418 St. Ambrose Ave. | | | | | |
| 18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) auricular fibrillation ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertension C-V Disease | | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | | | |
| 19. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours years | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from December 19 59 to Sept. 14, 19 65 , that (I) (we) last saw the deceased alive on Sept. 6, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Louis R. Maser | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9-16-65 | | |
| 23C. PHYSICIAN'S NAME (Type) Louis R. Maser, M.D. | | | | | 23D. ADDRESS 2724 Smith Ave. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/17/65 | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 17 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Wm. J. Johnson | | ADDRESS 4611 Park Heights Ave. | | | |



FUNERAL DIRECTOR: IMPORTANT

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| BIRTH NO. 65 9530 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9530 | |
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| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | Registered No. 65 9530 | |
| 1. NAME OF DECEASED (Type or Print) Johnson, Ulysses Sylvester | | | | 2. DATE AND HOUR OF DEATH September 15, 1965 1 45 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 University Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Baltimore City C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2430 Reisterstown Rd. | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 12/7/94 | 9. AGE (In years last birthday) 70 | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William Henry Johnson | | | | 14. MOTHER'S MAIDEN NAME Mollie Wanzer | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or date of service) No | | 16. SOCIAL SECURITY NO. 215-09-9922 | | 17. INFORMANT SELF | | ADDRESS | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CA of lung (Bronchogenic) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Metastatic Malignancy Pneumonia | | | | INTERVAL BETWEEN ONSET AND DEATH 10 wks 1 wk | | | |
| MEDICAL CERTIFICATION | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/16/68 to 9/15/68 and that (I) (we) last saw the deceased alive on 9/15 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Ralph Gardener | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Sept 15, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) RALPH GARDENER | | | | 23D. ADDRESS 3002 St PAUL St. Balto 18, Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-18-65 | | 24C. NAME of CEMETERY or CREMATORY Arbutus | | 24D. LOCATION (City, town, or county) (State) Arbutus Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 17 1965 | | 25B. NAME OF REGISTRAR Robert E. Tarkenton | | 25C. FUNERAL DIRECTOR ADDRESS MORRIS N. DYETI 1701 LAURENS ST. | | | |



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| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|------------------------------|
| 65 9531 | | 65 - 9531 | | 9501 | |
| M.E. CASE NO. | | | 1. NAME OF DECEASED | | |
| 1. NAME OF DECEASED (Type or Print) | | | DYSON, George Edward | | |
| 2. DATE AND HOUR OF DEATH | | | September 15, 1965 9:10 a.m. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE Maryland | | |
| Veterans Administration Hospital | | | B. COUNTY Baltimore | | |
| 3900 Loch Raven Boulevard | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | |
| Baltimore, Maryland 21218 | | | D. STREET ADDRESS (If rural, give location) | | |
| 1114 Sarah Ann Street | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | 10. CITIZEN OF WHAT COUNTRY? |
| Male | Negro | WIDOWED, DIVORCED (specify) Single | 5/19/14 | 51 | U.S.A. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Truck Driver | | unknown | | Crew, Virginia | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| George Dyson, Sr. | | | Edna Wynn | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| Yes 11/27/42 - 11/6/45 | | unknown | | VA Hospital Records, 3900 Loch Raven Boulevard Baltimore, Maryland 21218 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CAUSE OF DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | Broncho Pneumonia With Massive Aspiration Of Stomach Content. | | |
| ANTECEDENT CAUSES | | | Subarachnoid | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | Sub-Arachnoid Hemorrhage. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | Pulmonary Tuberculosis, Fibrocaceous and Cavitory. | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (this hospital) attended the deceased from September 13th 19 65 to September 15th 19 65, that (we) last saw the deceased alive on September 15th 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Anna R. Berkly | | | | 9/16/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| Anna R. Berkly | | | | VA Hospital, 3900 Loch Raven Boulevard Baltimore, Maryland 21218 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 9-19-65 | | Wynn Cem. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| SEP 17 1965 | | Robert E. Taylor | | Morton & Dyett Funeral Home, Balto., Md. | |

1944-1945

George H. ...

George H. ...

1944-1945

George H. ...

1944-1945

George H. ...

1944-1945

George H. ...

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1944-1945

George H. ...

1944-1945

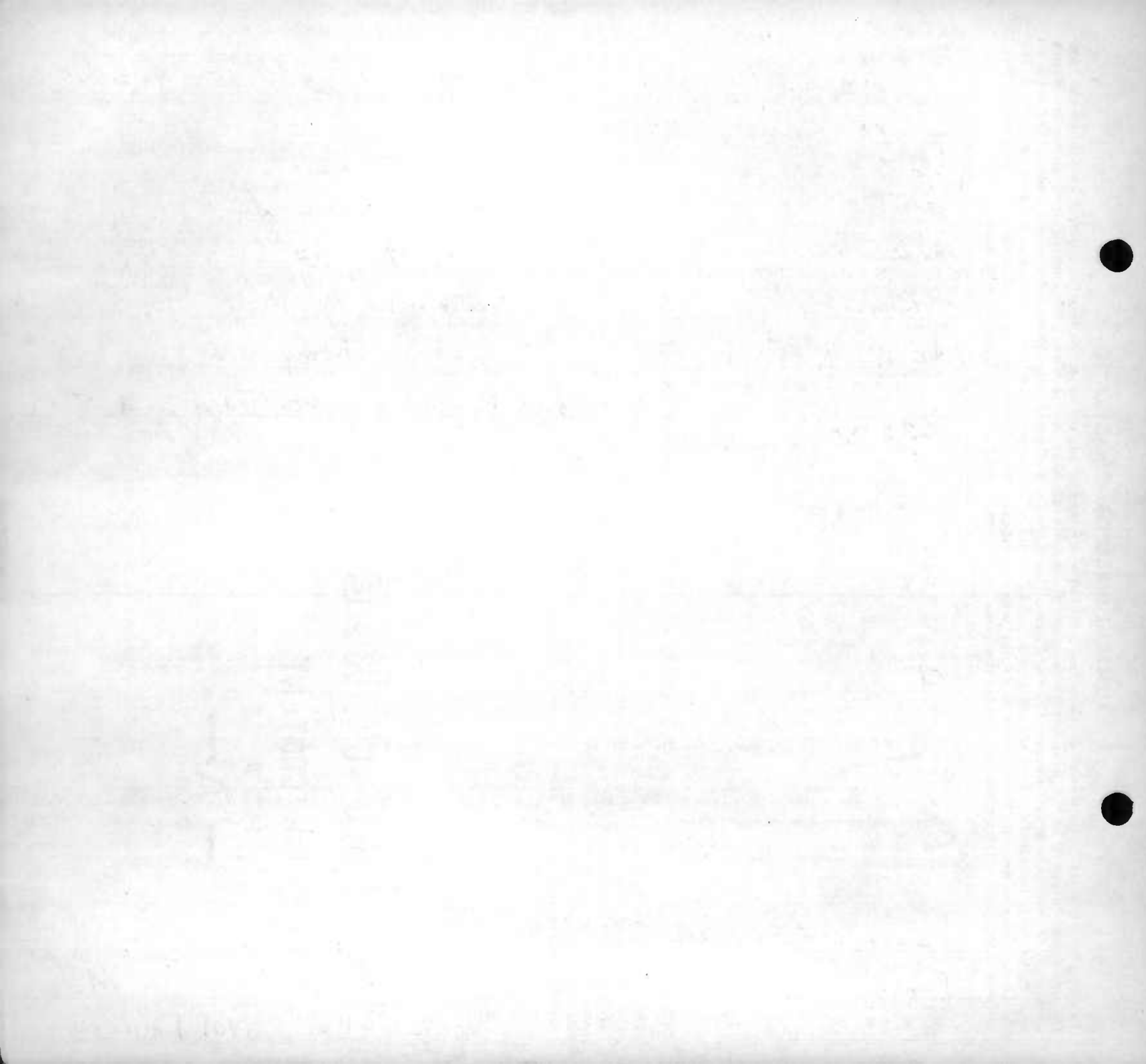
1944-1945

George H. ...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

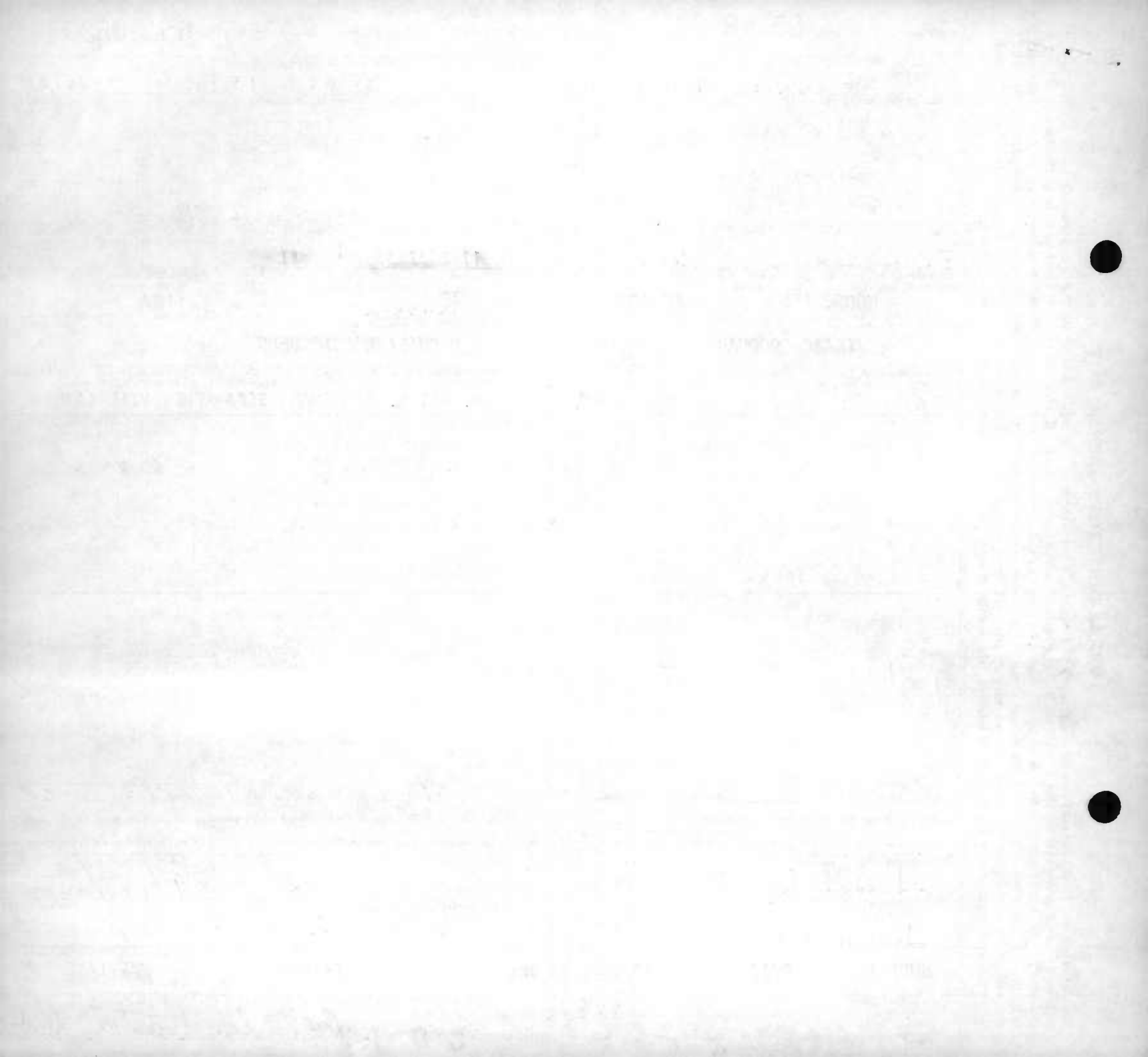
| Baltimore City Health Department | | | | Registered No. 65 9532 | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 65 9532 | | CERTIFICATE OF DEATH | | Registered No. 65 9532 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) JAMES THOMPSON (GRANT) | | 2. DATE AND HOUR OF DEATH 9/13/1965 6:45 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 16-08 Baltimore | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital of Maryland | | D. STREET ADDRESS (If rural, give location) 604 Edgewood St. | | | |
| 5. SEX Male | 6. RACE Colored | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 7/4/92 | 9. AGE (In years lost birthday) 73 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Worthington Va., Md. | 12. CITIZEN OF WHAT COUNTRY? U. S.A. |
| 13. FATHER'S NAME John W. Thompson | | 14. MOTHER'S MAIDEN NAME Luly Thompson | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 212-18-4235 | 17. INFORMANT R. Stanley | | ADDRESS 604 Edgewood St. |
| 18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Uncontrolled Diabetes Mellitus | | CAUSE OF DEATH (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/8 19 65 to 9/13 19 65 , that (I) (we) last saw the deceased alive on 9/13/65 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Inia C. Espina | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/13/65 | |
| 23C. PHYSICIAN'S NAME (Type) INIA C. ESPINA | | 23D. ADDRESS M.D. Lutheran Hospital of Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE 9-16-65 | 24C. NAME OF CEMETERY OR CREMATORY MT. AUBURN | 24D. LOCATION (City, town, or county) BALTO. | (State) Md | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 17 1965 | 25B. NAME OF REGISTRAR Robert E. Fabela | | 25C. FUNERAL DIRECTOR ADDRESS MORTON + DyeTT 1701. LAURENS | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. 65 9533 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9533 | |
| M.E. CASE NO. | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) FANNIE PINERMAN | | | 2. DATE AND HOUR OF DEATH SEPT 15, 1965 7:15 AM. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-20 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI HOSPITAL OF BALTO. INC. | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | |
| D. STREET ADDRESS (If rural, give location) 3906 BROOKHILL ROAD | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 5. SEX FEMALE CAUC. | 6. RACE CAUC. | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 11/22/1883 | 9. AGE (In years last birthday) 81 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | | |
| 13. FATHER'S NAME ISAAC GOODMAN | | | 14. MOTHER'S MAIDEN NAME RACHAEL KOENIGSBERG | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. NO | | |
| 17. INFORMANT MR. ELI H. PINERMAN | | | ADDRESS 3506 SEVEN MILE LANE | | |
| 18. 13331 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) CARCINOMATOSIS DUE TO (B) CARC. OF STOMACH DUE TO (C) | | | INTERVAL BETWEEN ONSET AND DEATH 6 DAYS | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 1/9/12/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED INT. OBSTRUCTION | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/9 19 65 to 9/15 19 65 that (I) (we) last saw the deceased alive on 9/14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Jerome Reichmister M.D. | | | | 23B. DATE SIGNED 9/15/65 | |
| 23C. PHYSICIAN'S NAME (Type) JEROME REICHAISTER | | | | 23D. ADDRESS SINAI HOSPITAL OF BALTO. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/16/65 | | 24C. NAME OF CEMETERY or CREMATORY BALTIMORE HEBREW | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT. SEP 17 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Fisher | | 25C. FUNERAL DIRECTOR Ad. Levine & Bros. Inc. 6000 Reisterstown Road | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 65 9534 | | CERTIFICATE OF DEATH | | Registered No. 65 9534 | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--------------------------------------------------------------------------|-------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|----------------------|--|
| 1. NAME OF DECEASED (Type or Print) MORRIS EISEN | | | | 2. DATE AND HOUR OF DEATH 9/14/65 4:35 A.M. | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSP. of BALTO, INC. 42 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MD. B. COUNTY BALTIMORE CITY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21215 D. STREET ADDRESS (If rural, give location) 7121 PARK HEIGHTS AVE. | | | | | | |
| 5. SEX MALE | 6. RACE CAUCASIAN | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 10/9/92 | 9. AGE (In years last birthday) 72 | If Under 1 Yr. Months: Days: Hours: Min. | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWNER- CATS PAW | | | 10B. KIND OF BUSINESS OR INDUSTRY RUBBER HEEL CO. | | | 11. BIRTHPLACE (State or foreign country) RUSSIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME HIRSH EISEN | | | | 14. MOTHER'S MAIDEN NAME SARAH ? | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 213-05-3221 | | 17. INFORMANT FLORENCE FINEMAN: 11 | | | ADDRESS 21208 SCADY AVE | | |
| 18. 161X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. chr. obstructive airway disease & emphysema & chr. bronchitis Myocardial insufficiency | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| | | | | (A) possible recurrent sq. Ca. DUE TO | | > 1 yr. | | | | |
| | | | | (B) possible post-irradiation fibrosis DUE TO | | > 5 yrs. | | | | |
| | | | | (C) Sub-glottal squamous Carcinoma | | 9 yrs | | | | |
| 19A. DATE OF OPERATION 2 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED chr. obstructive airway disease & emphysema & chr. bronchitis | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NONE | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NONE | | | | |
| 21D. TIME OF INJURY (APPROX.) NONE | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> NONE | | 21F. HOW DID INJURY OCCUR? NONE | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/13/65 10AM 19 65 to 9/14/65 4AM 19 65 , that (I) (we) last saw the deceased alive on 9/14/65 4:35AM 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE Joseph S. Weinstock M.D. | | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/14/65 | | |
| 23C. PHYSICIAN'S NAME (Type) Joseph S. Weinstock | | | | | | 23D. ADDRESS M.D. SINAI HOSP. of BALTO. INC. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/15/65 | | 24C. NAME OF CEMETERY or CREMATORY BETH TFILOH | | 24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 17 1965 | | | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. | | | 25C. FUNERAL DIRECTOR Sol LEXINGTON + Bros. Inc. 6010 Reisterstown | | | ADDRESS RD | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 65 9535 | | CERTIFICATE OF DEATH | | Registered No. _____ | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------|--|
| BIRTH NO. | | | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | | | | | Ruth Ann Nugent | | 9-16-65 10:30 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | A. STATE | | B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | | | (If not in hospital or institution, give street address or location) | | Md. | | 20-02 | |
| 2302 W. Fayette St. | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore | |
| | | | | | | D. STREET ADDRESS (If rural, give location) | | 2302 W. Fayette St. | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | |
| Negro | | Negro | | Wid. | | 2-8-1894 | | 71 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Housewife | | | | | | Clarksburg, Md. | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| David Snowden | | | | Harriet Bowie | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| | | | | | | Hattie Burley Laurel, Md. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | | | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO | | | | | |
| II | | | | Diabetes mellitus | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | Congestive Heart Failure (chronic) | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| O | | | | No | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from May 11, 1965 to September 16, 1965, that (I) (we) last saw the deceased alive on May 11, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | M.D. | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| R. Blackman | | | | | | | | 9/16/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | |
| | | | | M.D. | | 255 - N. Payson St. Balt., Md. 21223 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) | | (State) | |
| Burial | | 9-20-65 | | Lincoln Mem Cem. | | Washington | | D. C. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | |
| SEP 17 1965 | | Robert E. Taylor, M.D. | | Morton A. Dyett | | 1701 Laurens St | | | |

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|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. 65 9536 | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 9536 | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. | | | | | |
| M.E. CASE NO. | | | 2. DATE AND HOUR PRONOUNCED DEAD | | |
| 1. NAME OF DECEASED (Type or Print) | | | September 12, 1965 1:00 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | A. STATE Maryland | | |
| 2516 Harford Road | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | | |
| | | | Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) | | |
| | | | 2516 Harford Road | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| Male | White | Widower | January 15, 1893 | 72 | 60 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Shipping Clerk-Ret. | | Picker X-Ray Co. | | Southampton, England | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| James Henry Frost | | | Alice Thomas | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 21 280 086 | | Family Records | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | | |
| Arteriosclerotic heart disease | | | | | |
| (A) DUE TO | | | | | |
| II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | | |
| (B) DUE TO | | | | | |
| (C) DUE TO | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | No | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 9-13-65 | |
| Russell S. Fisher, M.D. | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME of CEMETERY or CREMATORY | |
| Burial | | Sept. 15, 1965 | | Prospect Hill Cemetery | |
| | | | | Towson, Maryland | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR ADDRESS | |
| SEP 17 1965 | | Robert E. Fairbank | | John Burns' Sons, Towson, Maryland | |

James H. Brown

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|----------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------------|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 9537 | | | | |
| BIRTH NO. 65 9537 | | | | | M.E. CASE NO. 65 9537 | | | | |
| 1. NAME OF DECEASED (Type or Print) Mrs. MILDRED G. EARLE | | | | | 2. DATE AND HOUR OF DEATH 9-12-65 8:57 P.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Md B. COUNTY Balto | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home Hosp. | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Middle River 5300 | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) Box 245, Rt. 15 | | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH 7-2-97 | 9. AGE (In years last birthday) 68 | 10. Under 1 Yr. Months Days | | 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H. Wife | | 10B. KIND OF BUSINESS OR INDUSTRY Housewife | | 11. BIRTHPLACE (State or foreign country) Md Balto. | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME George Kearney | | | | | 14. MOTHER'S MAIDEN NAME Gertrude Stewart | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | | 16. SOCIAL SECURITY NO. 220-38-8223 | | 17. INFORMANT Chart | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | CAUSE OF DEATH (A) DUE TO Direct Posterior & diaphragmatic & Anterior myocardial infarction Acute | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | | (B) DUE TO Arterio-sclerotic narrowing of Rt. coronary artery & occlusion of Lt. coronary | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | (C) DUE TO | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE A.E. SUBONG, JR. | | | | | 23B. DATE SIGNED | | | 23C. PHYSICIAN'S NAME (Type) A.E. SUBONG, JR. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | | 24B. DATE 9-16-1965 | | 24C. NAME OF CEMETERY or CREMATORY Oaklawn Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore Co. Md. |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 17 1965 | | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | | 25C. FUNERAL DIRECTOR Lazarus Funeral Home | | | 25D. ADDRESS Lazarus Funeral Home |

0

7

Dear Father
 I have just received
 your letter of the 10th
 and am glad to hear
 from you. I am well
 and hope this finds
 you the same. I am
 ever your affectionate
 son
 John

69

20 42-6-7

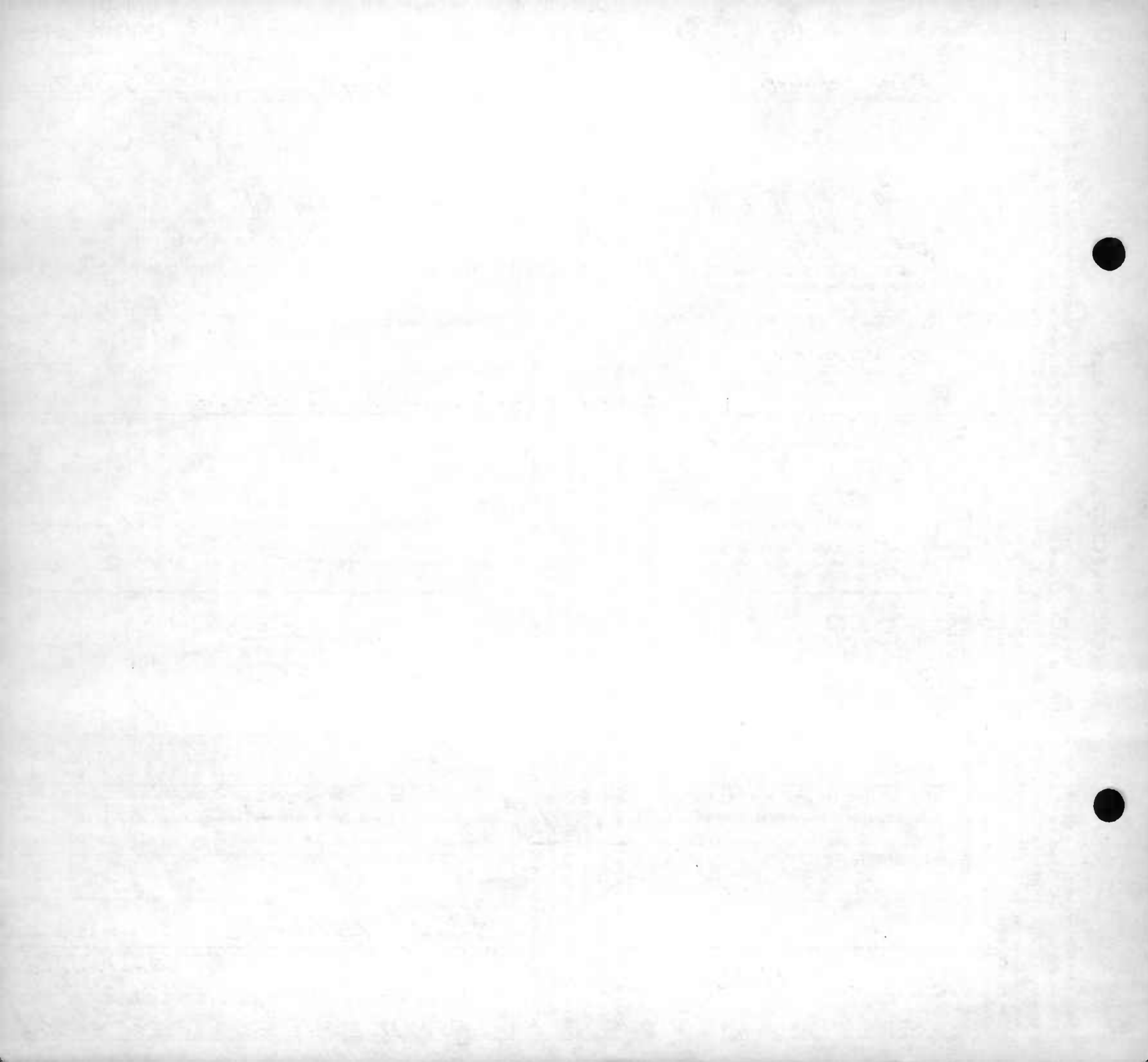
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9539 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9539 | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------|------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------|------------------------------------------------------------------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) <u>Rose Sokolove</u> | | | |
| 2. DATE AND HOUR OF DEATH <u>9/15/65</u> <u>5:50 A</u> M. | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>42 Sinai Hospital of Baltimore</u> | | | | A. STATE <u>Maryland</u> B. COUNTY <u>15-11</u> | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | | D. STREET ADDRESS (If rural, give location) <u>3307 Dorthan Rd.</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>9/24/94</u> | 9. AGE (In years last birthday) <u>70</u> | If Under 1 Yr. Months: Days: | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>-</u> | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>UNKNOWN</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Schein</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>215-10-7720</u> | | 17. INFORMANT <u>Schemen Sokolove</u> | |
| 18. <u>443XV-170X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | | | (A) <u>HCV D (Hypertensive Cardiovascular Disease)</u> DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) <u>CVA (Cerebral Vascular Accident)</u> DUE TO | | | |
| | | | | (C) <u>Ca of Breast - possible metastasis</u> | | <u>10 yrs ago</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | <u>Ca of Breast - possible metastasis</u> | | <u>10 yrs ago</u> | |
| 19A. DATE OF OPERATION <u>21-</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u> | | 20A. AUTOPSY (Yes or No) <u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u> | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u>-</u> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <u>-</u> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9/14/65</u> 19 <u>65</u> to <u>9/15/65</u> 19 <u>65</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>9/14/65</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Robert L. Handwagner</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>9/15/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>SINAI Hospital</u> | | | | 23D. ADDRESS <u>SINAI Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9/17/65</u> | | 24C. NAME of CEMETERY or CREMATORY <u>RODEF ZEDECK Cong</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 17 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert L. Handwagner</u> | | 25C. FUNERAL DIRECTOR <u>TRAPLINSKY INC - 2100-2 EUTAW PK</u> | | ADDRESS <u>BALTIMORE CITY Md.</u> | |



| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | Registered No. | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|----------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------------------------|------------------------|----------------------------------------------------------------------|------------------------------|
| 65 9540 | | | | 65 9540 | | | |
| M-220 | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR PRONOUNCED DEAD | | | |
| BERNICE MAZYCK | | | | September 14, 1965 12:55 P.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE | | | |
| 39 Provident Hospital | | | | Maryland | | | |
| | | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | | | |
| | | | | Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | 1816 Bolton Street | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. UNDER 1 Yr. Months | 11. UNDER 24 Hrs. Days | 12. CITIZEN OF WHAT COUNTRY? |
| female | negro | Married | 1/29/44 | 20 | | | USA |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Domestic | | | | South Carolina | | USA | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| William Green, Sr | | | | Hester Cooper | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown. If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| | | | | Mr William Green, Jr 107 E End St, S. C | | | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) Multiple traumatic injuries DUE TO | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | (B) DUE TO | | | |
| | | | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 2 | | | | Yes | | Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | home | | 1816 Bolton Street | | 14-01 | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| 9 14 65 11:04 | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | Allegedly fell out of window | | | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER | | DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| Rudiger Breitenecker, M.D. | | M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | September 14, 1965 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME of CEMETERY or CREMATORY | | 23D. LOCATION (City, town, or county) (State) | |
| Burial | | 9/18/65 | | Mullins | | South Carolina | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR | | ADDRESS | |
| SEP 17 1965 | | | | Adolphus Halstead | | 1206 W North Ave | |

WALLLEY PORGE

1946 CONTENT

Handwritten signature

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9541 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9541 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------------------------------------------------|-----------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| Douglass, Booker | | | | September 14, 1965 12:25a M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| Provident Hospital | | 1514 Division Street | | Maryland | | 17-02 | |
| Baltimore, Maryland 21217 | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore | |
| D. STREET ADDRESS (If rural, give location) | | | | 1330 N. Brunt Street | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days | | If Under 24 Hrs. Min. |
| Male | Negro | married | Oct. 3, 1903 | 63 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| unknown | | unknown | | Tennessee | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| John Douglass | | | | unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| | | | | Mildred Douglass-wife | | same | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | (A) Cerebro-vascular accident | | | |
| (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) | | | | DUE TO | | | |
| ANTECEDENT CAUSES | | | | (B) Diabetes mellitus | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | DUE TO | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | (C) | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 0 | | | | no | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from September 11, 1965 to September 14, 1965, that (I) (we) last saw the deceased alive on September 14, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | September 14, 1965 | |
| Andre Rigaud | | | | M.D. 1514 Division Street - Baltimore 17, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 9/17/65 | | Mt Calvary Cemetery | | A A County Md | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| SEP 17 1965 | | Robert E. Farber | | Adolphus Halstead | | 1206 W North Ave | |

Handwritten signature

65 9542

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 9542

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM M. HARRIS

2. DATE AND HOUR PRONOUNCED DEAD

9/16/65 7:35 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

48 Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

417 W. Biddle St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

6/19/00

9. AGE (In years
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Portsmouth Va

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Catherine

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.
137-14-5016

17. INFORMANT

ADDRESS

Mrs Lola Harris 417 W Biddle St

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Bronchopneumonia

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
(If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner H. Spitz M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/16/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/18/65

23C. NAME OF CEMETERY or CREMATORY

Mt Calvary Cemetery

23D. LOCATION

(City, town, or county)

(State)

A A County Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 17 1965

Robert E. Farkner

Adolphus Halstead 1206 W North Ave

VALLEY FORGE

ALL CONTENT

1/1/1

1/1/1

1/1/1

1/1/1

1/1/1

1/1/1

1/1/1

1/1/1

1/1/1

1/1/1

1/1/1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | 65 9543 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9543 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|----------------------------------------------------------------------|-----------------------|
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | HARRY DAPP | | 2. DATE AND HOUR OF DEATH Sept. 16, 1965 5 ¹⁵ A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSPITAL | | | | A. STATE B. COUNTY MARYLAND | | | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 5 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 503 WOLFE ST. | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 7-20-1907 | 9. AGE (In years lost birthday) 58 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Pa | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME HARRY DAPP | | | | 14. MOTHER'S MAIDEN NAME ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 216-05-4815 | | 17. INFORMANT Dorothy Dapps | | ADDRESS 503 W. Wolfe St | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) I 162.1 CAUSE OF DEATH (A) Bronchogenic carcinoma DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH 9 months | | | | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec. 13, 1964 to present 1965, that (I) (we) last saw the deceased alive on Sept. 10, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE James R. Klinenberg | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Sept. 16, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) DR. JAMES KLINENBERG | | | | 23D. ADDRESS M.D. The Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) Cremation | | 24B. DATE Sept 17/65 | | 24C. NAME OF CEMETERY or CREMATORY Greenmount | | 24D. LOCATION (City, town, or county) (State) Baltimore | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 17 1965 | | 25B. NAME OF REGISTRAR P. G. E. Fairbank | | 25C. FUNERAL DIRECTOR Philip Hewing | | ADDRESS 2024 Orleans St | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|----------------------------------------------------------------------|--------------------------------------------|--|
| M 460 1 65 9544 CERTIFICATE OF DEATH | | | | | Registered No. 65 9544 | | | | |
| BIRTH NO. 65 9544 | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) Lankford Miller (Lankford Miller) | | | | | 2. DATE AND HOUR OF DEATH 9-8-65 7:30 A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital | | | | | A. STATE Maryland | | | | |
| | | | | | B. COUNTY 5-01 | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 1435 East Fayette Street | | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | | 8. DATE OF BIRTH 5-7-05 | 9. AGE (In years last birthday) 60 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labourer | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME William Miller | | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Hospital Record | | | ADDRESS | |
| 18. 4-20-1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) Myocardial Infarction DUE TO (B) HASCVD and chronic CHF DUE TO (C) | | | INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) did not attended the deceased from Sept. 1 19 65 to Sept. 8 19 65, that (I) was last saw the deceased alive on Sept. 7 19 65 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE George A. Scheedle | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED 9/8/65 | |
| 23C. PHYSICIAN'S NAME (Type) George A. Scheedle | | | | | 23D. ADDRESS The Johns Hopkins Hospital | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-13-65 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem. A. A. Co | | 24D. LOCATION (City, town, or county) (State) Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 17 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Raymond Sanders | | 25D. ADDRESS 217 E. Preston St | | | |

12/1/62

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9545 | |
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| BIRTH NO. 65 9545 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) ROSIE LEE | | | 2. DATE AND HOUR OF DEATH 9-8-65 1:40P M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 9-08 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1926 N. AISQUITTH | | |
| 5. SEX FEMALE | 6. RACE COLORED | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) 8-14-44 MARRIED | 8. DATE OF BIRTH 8-14-14 | 9. AGE (In years lost birthday) 51 | If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore | |
| 13. FATHER'S NAME ADOLPHUS ST. ROSE | | | 14. MOTHER'S MAIDEN NAME WILLIE ANN BURNETT | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Hospital Record ADDRESS | |
| 18. 441X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) UREMIA DUE TO (B) MALIGNANT HYPERTENSION DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 1 month 6 months |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CARDIAC FAILURE | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from August 13 19 65 to Sept. 8 19 65 , that (I) (we) last saw the deceased alive on Sept. 8 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Nicholas J. Fortuin | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9.8.65 |
| 23C. PHYSICIAN'S NAME (Type) NICHOLAS J. FORTUIN | | | 23D. ADDRESS The Johns Hopkins Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-13-65 | | 24C. NAME of CEMETERY or CREMATORY Baltimore National Cem. Balto | |
| 24D. LOCATION (City, town, or county) (State) Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 17 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR Rayner Sanders | | 25D. ADDRESS 217 E. Preston St. | | | |

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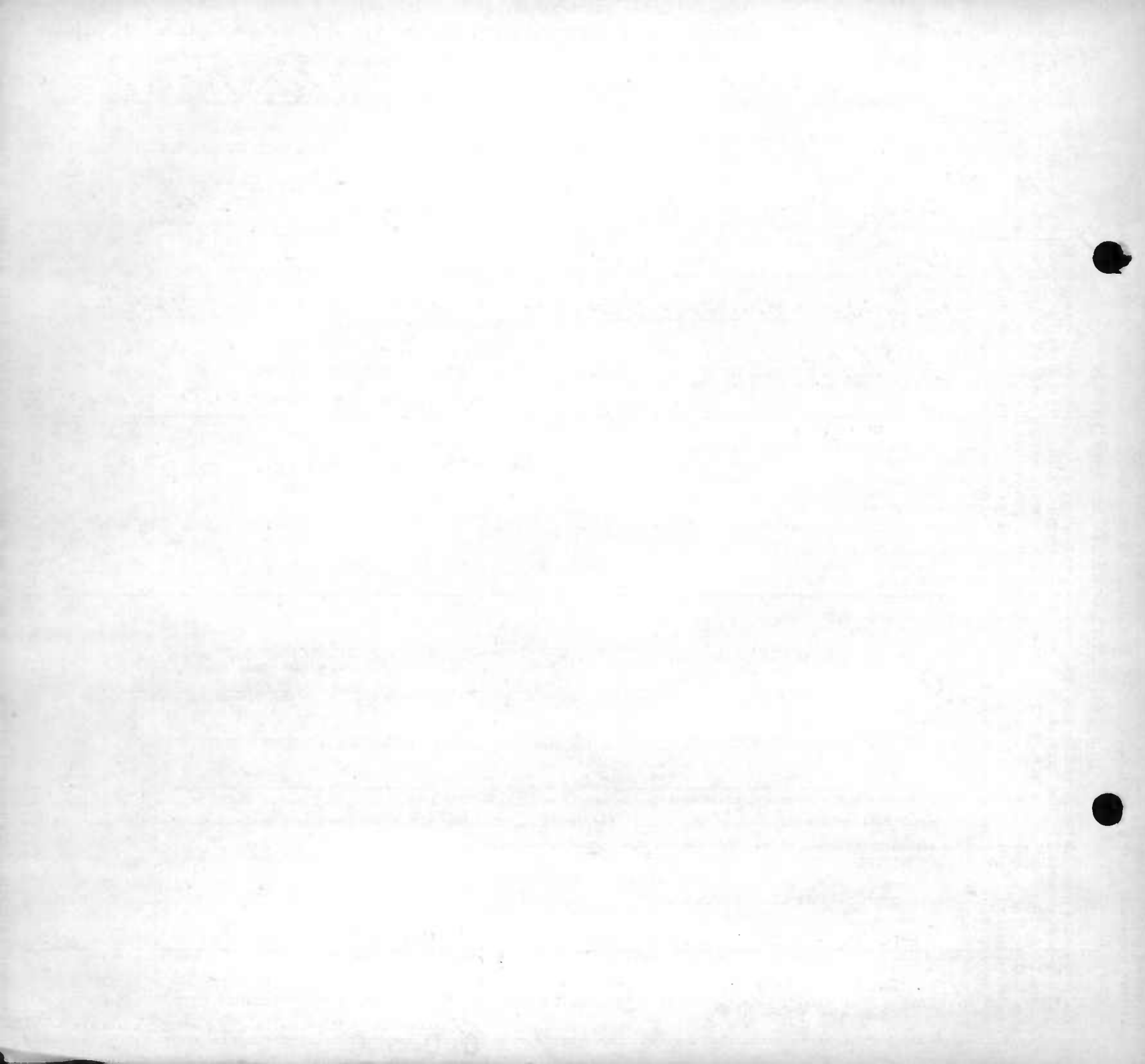
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9546 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9546 | |
| M.E. CASE NO. | | | 1. NAME OF DECEASED (Type or Print) MAJOR COSTON | | |
| 2. DATE AND HOUR OF DEATH 9-15-1965 1:55 A.M. | | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY 4-02 | | | 5. SEX M 6. RACE Col 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | 8. DATE OF BIRTH 9. AGE (In years lost birthday) 69 | | |
| D. STREET ADDRESS (If rural, give location) 221 N. FREMONT AVE Apt 108 | | | 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LINESHOREMAN RET. 10B. KIND OF BUSINESS OR INDUSTRY PORT OF BALTO. | | |
| 11. BIRTHPLACE (State or foreign country) ACCOMAC CO. VA | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME William Coston | | | 14. MOTHER'S MAIDEN NAME Unknown | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 217-01-9888 | | |
| 17. INFORMANT MAMIE (COSTON) | | | ADDRESS 221 N. FREMONT AVE | | |
| 18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH (A) Cerebral hemorrhage DUE TO | | |
| ANTECEDENT CAUSES (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | (B) Atherosclerosis Hypertension DUE TO | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-13-1965 to 9-15-1965, that (I) (we) last saw the deceased alive on 9-14-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Frank A. Saunders M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED 9-17-65 | |
| 23C. PHYSICIAN'S NAME (Type) FRANK A. SAUNDERS M.D. | | | | 23D. ADDRESS 1029 n. Stricker St. Baltimore 21217 Md | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/18/65 | | 24C. NAME OF CEMETERY OR CREMATORY Baitman | |
| 24D. LOCATION (City, town, or county) Baltimore | | 24E. DATE REC'D BY HEALTH DEPT. SEP 17 1965 | | 24F. NAME OF REGISTRAR Robert E. Taylor | |
| 24G. FUNERAL DIRECTOR Maudine Roberts | | 24H. ADDRESS 638 N. Green St | | | |



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65 9547

BALTIMORE CITY HEALTH DEPARTMENT

65 9547

BIRTH NO. 60-32768 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) ANGELA MATTHEWS 2. DATE AND HOUR PRONOUNCED DEAD 12 September 1965 8:50 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University Hospital C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 25-33

D. STREET ADDRESS (If rural, give location) 2218 Norfolk St.

5. SEX female 6. RACE negro 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Single 8. DATE OF BIRTH Nov 2, 1960 9. AGE (In years last birthday) 4

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME Clarence Taylor 14. MOTHER'S MAIDEN NAME Sarah Matthews

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. None 17. INFORMANT ADDRESS Mrs. Sarah Matthews 2218 Norfolk St

18. CAUSE OF DEATH

18. CAUSE OF DEATH

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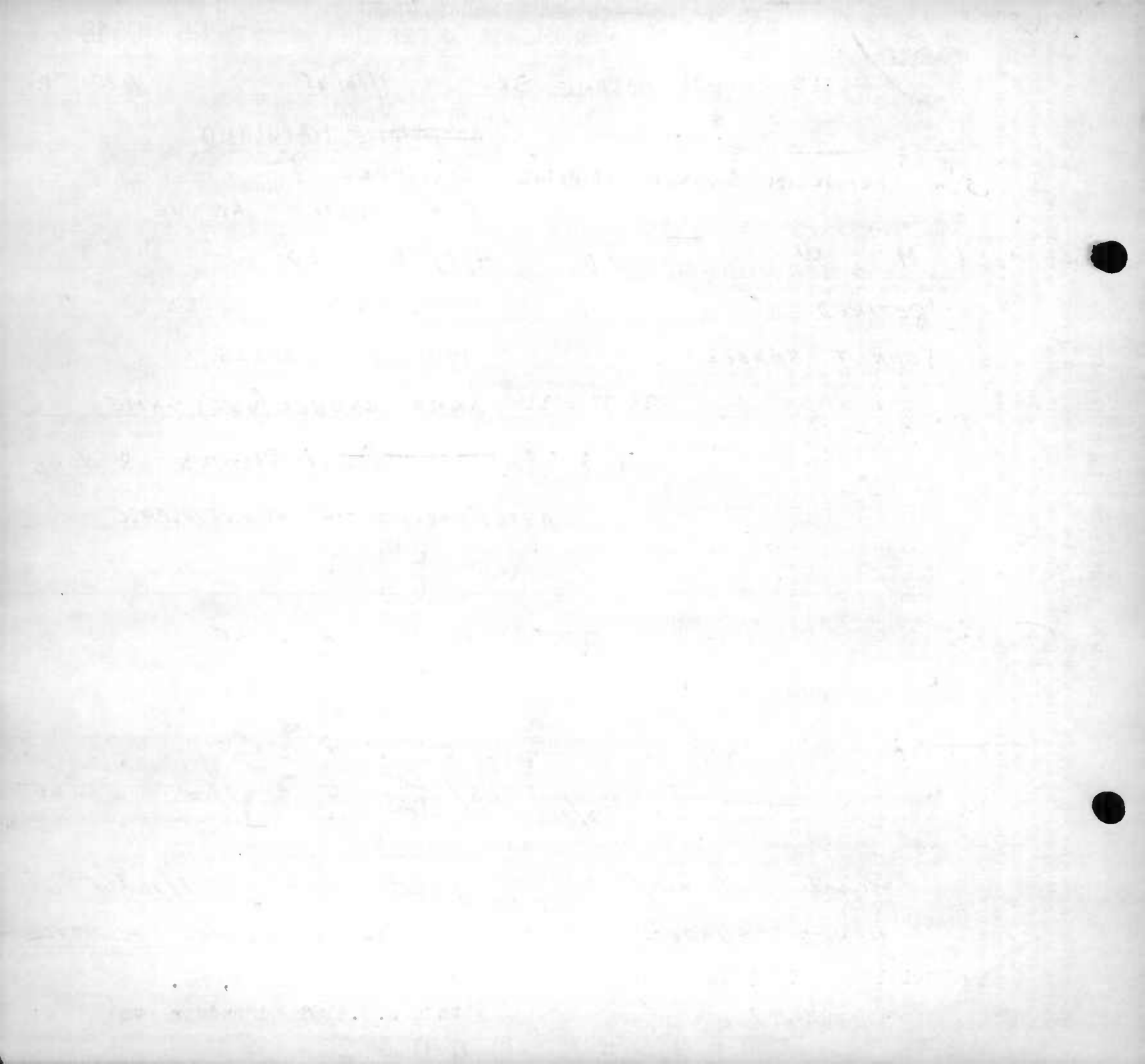
18. CAUSE OF DEATH

WALTER DODGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9548 | |
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| BIRTH NO. 65 9548 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) BARBER, ROBERT MCCLANE SR. | | 2. DATE AND HOUR OF DEATH 9/16/65 1:10 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION FRANKLIN SQUARE HOSPITAL | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 7 | | | |
| | | D. STREET ADDRESS (If rural, give location) 5940 HILLTOP AVENUE | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 4/1/03 | 9. AGE (In years last birthday) 62 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME JOHN T. BARBER | | 14. MOTHER'S MAIDEN NAME MINNIE GESSELS | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 212 07 9611 | | 16. SOCIAL SECURITY NO. 212 07 9611 | | 17. INFORMANT ADDRESS ANNA BARBER (WIFE) SAME | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction 8 days | | CAUSE OF DEATH (A) Acute Myocardial Infarction 8 days (B) ARTERIOSCLEROTIC HEART DISEASE (C) | | INTERVAL BETWEEN ONSET AND DEATH 8 days | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | OSTEOARTHRITIS OF SPINE | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (natively medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/8/65 19 to 9/16 19 65 , that (I) (we) last saw the deceased alive on 9/16 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Nenita Suarez | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/16/65 | |
| 23C. PHYSICIAN'S NAME (Type) NENITA SUAREZ | | 23D. ADDRESS FRANKLIN SQUARE HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/20/65 | | 24C. NAME of CEMETERY or CREMATORY Lorraine Park | |
| 24D. LOCATION (City, town, or county) (State) Baltimore 7, Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 17 1965 | | 25B. NAME OF REGISTRAR Robert E. Fajana | |
| 25C. FUNERAL DIRECTOR Witzke F.D. 4101 Edmondson Ave | | ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9549 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9549 | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) James K. Macek | | | | 2. DATE AND HOUR OF DEATH September 12, 1965 | | M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| 5. SEX M | | | | 6. RACE W | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | |
| 8. DATE OF BIRTH 6 - 25 - 99 | | | | 9. AGE (In years last birthday) 66 | | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder | | | | 10B. KIND OF BUSINESS OR INDUSTRY American Standard | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME John Madek | | | |
| 14. MOTHER'S MAIDEN NAME Unknown | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. 213-01-4428 | | | | 17. INFORMANT Mrs. Stella Macek | | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH (A) Hypertension C.V.D. (B) Generalized Atherosclerosis (C) Coronary Artery Disease | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 1963 to Sept 12 1965, that (I) (we) last saw the deceased alive on Sep. 10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Melvin J. Jaworski | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9/15/65 | |
| 23C. PHYSICIAN'S NAME (Type) Melvin J. Jaworski | | | | 23D. ADDRESS 2711 Eastern Ave | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/16/65 | | 24C. NAME of CEMETERY or CREMATORY Holy Rosary Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 17 1965 | | 25B. NAME OF REGISTRAR Robert E. Fawcett | | 25C. FUNERAL DIRECTOR Charles L. Stevens Funeral Home, Inc. 800 E. Fort Avenue | | | |

1. The first part of the
document is a letter from
the author to the editor.

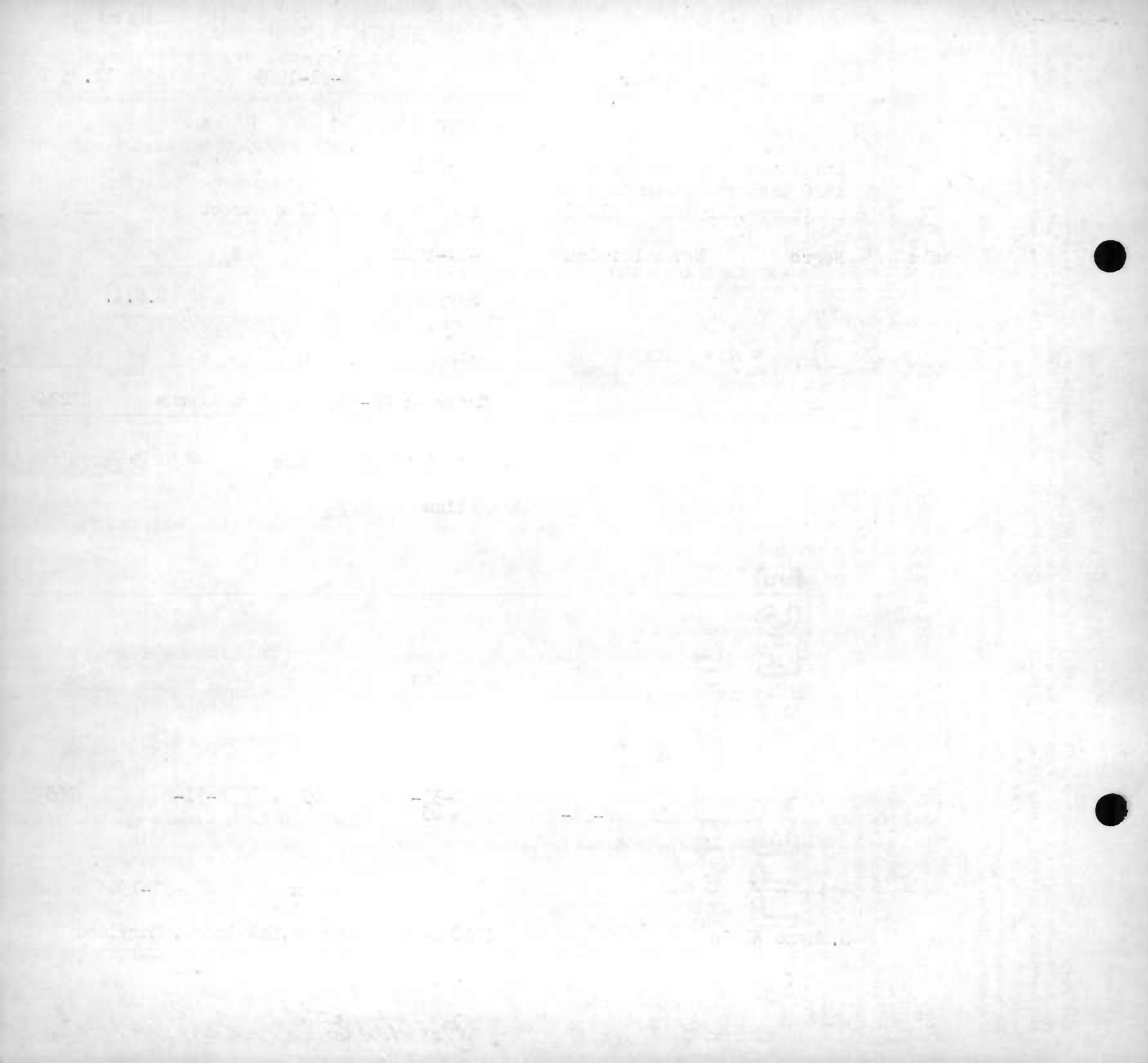
2. The second part of the
document is a letter from
the editor to the author.

5-656

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

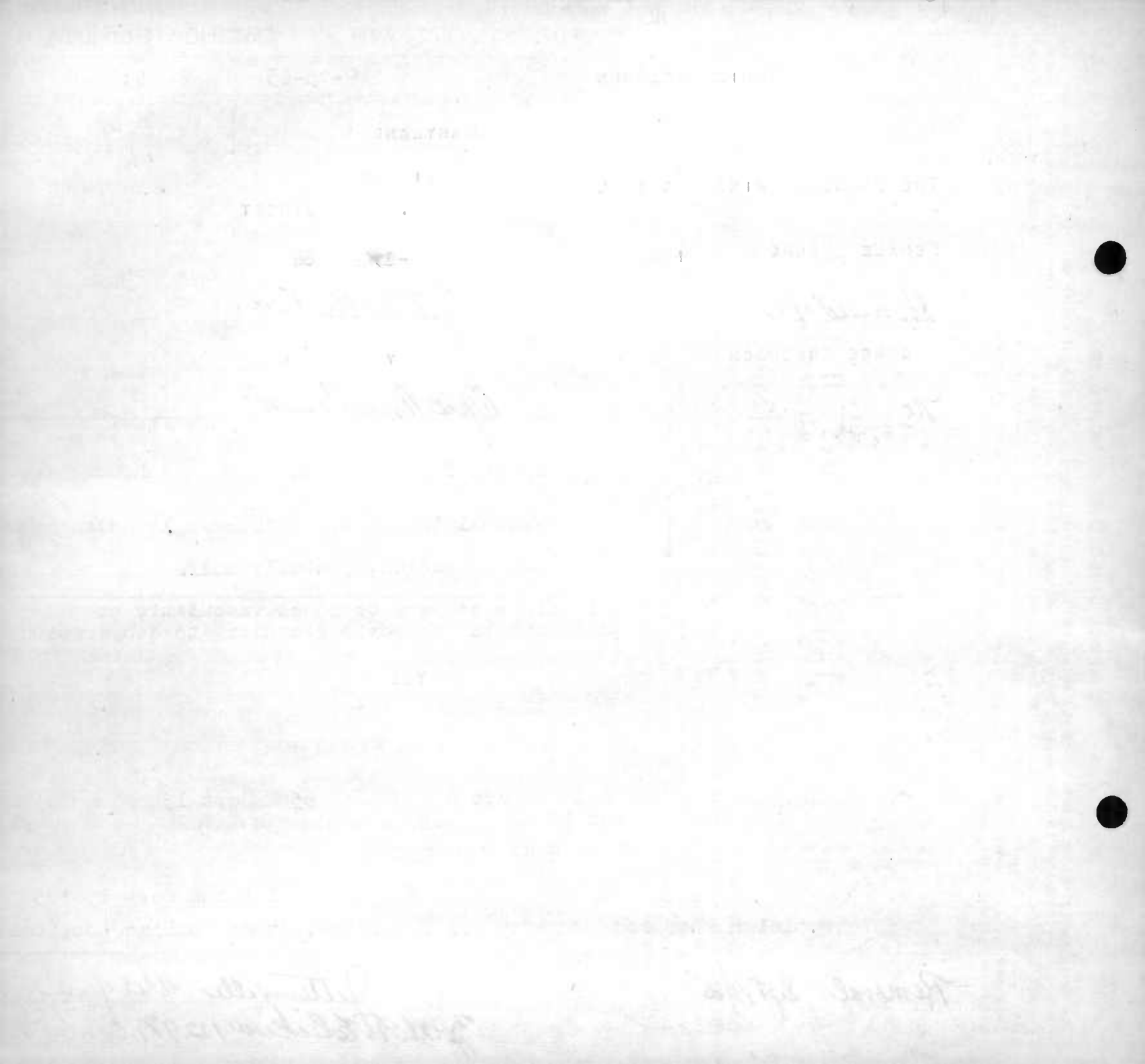
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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. 62-17340 65 9550 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9550 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Gregory Garner | | 8-31-1965 | | 11.35 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE Maryland | | B. COUNTY 7-AY | |
| Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| D. STREET ADDRESS (If rural, give location) | | 1047 North Caroline Street | | 21205 | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Never Married | 8. DATE OF BIRTH 6-25-1962 | 9. AGE (In years last birthday) 3 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Waller R. Garner | | 14. MOTHER'S MAIDEN NAME Lillian Turner | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Congenital Heart Disease DUE TO Mongolism (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 3 years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 8-31-1965 to 8-31-1965, that (I) (we) last saw the deceased alive on 8-31-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE S. Wayne Klein | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 8-31-1965 | |
| 23C. PHYSICIAN'S NAME (Type) S. Wayne Klein | | 23D. ADDRESS M.D. 4940 Eastern Avenue, Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Sept 4/65 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery | |
| 24D. LOCATION (City, town, or county) (State) A.A. County Md | | 25A. DATE REC'D BY HEALTH DEPT. SEP 17 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR Milton E. Ellickson | | ADDRESS 1129 N. Calhoun | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9551 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9551 | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------|-----------------------|----------------------------------------------------------------------|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| ANNIE ANDERSON | | | | 9-15-65 | | 4:30 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| THE JOHNS HOPKINS HOSPITAL | | | | MARYLAND 12-04 | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | | | BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | 207 E. 23RD STREET | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birth day) | If Under 1 Yr. Months | If Under 24 Hrs. Days | |
| FEMALE | NEGRO | WIDOW | 10-14-1900 | 64 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Housewife | | | | Jetersville Va. | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| GEORGE ANDERSON | | | | MARY WOODSON | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| No | | | | Opie Ann Townes | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) Myocardial infarction | | 8 hours | |
| ANTECEDENT CAUSES | | | | (B) Vasculitis | | 14 days | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) Drug reaction, probably sulfa | | | |
| II | | | | Oliguria secondary to renal vasculitis or acute tubular necrosis secondary to dehydration | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 4 19 65 to Sept 15 19 65, that (I) (we) last saw the deceased alive on Sept 15 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| W. Leigh Thompson | | | | Interne Sept 15 '65 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| W. Leigh Thompson | | | | Osler Service, Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Removal | | Sept 18/65 | | | | Jetersville Virginia | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME of REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| SEP 17 1965 | | Robert E. Jones | | John A. Elicker | | 11297 N. Charles St. | |



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

MANDEL SENER

2. DATE AND HOUR PRONOUNCED DEAD

9/15/65 8:15 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1616 Rickenbacker Rd.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Divorced

8. DATE OF BIRTH

June 7, 1908

9. AGE (In years
last birthday)

57

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Accountant

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?
USA

13. FATHER'S NAME

Sener

14. MOTHER'S MAIDEN NAME

Carrie Beck

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

Mrs. Constance DeLancy, Keene, N.H.

ADDRESS

94 Colonial Drive

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/16/65

23A. BURIAL CREMATION,
REMOVAL (Specify)
Cremation

23B. DATE

9-18-65

23C. NAME of CEMETERY or CREMATORY

Green Mount Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 17 1965

Robert E. Farley, Jr.

Ullrich Funeral Home Baltimore, Md.

VIA RAIL
F. POLICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. <u>65 9553</u> | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|-----------------------------------------------------------------------------|--|
| BIRTH NO. <u>65 9553</u> | | M.E. CASE NO. <u>65 9553</u> | | 1. NAME OF DECEASED (Type or Print) <u>John Goetz</u> | | 2. DATE AND HOUR OF DEATH <u>9-16-65</u> <u>2:20 PM</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Church Home and Hospital</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside City limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>103 N. Decker Avenue</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>2-21-95</u> | 9. AGE (In years lost birthday) <u>69</u> <u>70</u> | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>DANIEL GOETZ</u> | | | | 14. MOTHER'S MAIDEN NAME <u>ELIZABETH CLINTON</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u> <u>WW 1</u> | | 16. SOCIAL SECURITY NO. <u>280-10-3530</u> | | 17. INFORMANT ADDRESS <u>Mr. George Chaney 108 N. East Ave.</u> | | | |
| 18. <u>15-2X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CAUSE OF DEATH</u> (A) <u>CARCINOMA TOSIS</u> DUE TO (B) <u>CARCINOMA of PANCREAS</u> DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH <u>weeks</u> <u>months</u> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>no</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>8-25</u> 19 <u>65</u> to <u>9-16</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>9-16</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>José S. Masrog</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED <u>9-16-65</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>José S. Masrog</u> | | | | 23D. ADDRESS <u>Church Home and Hospital</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9/20/65</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 17 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Galt</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>John A. Moran, Inc. 3000 E. Balto. St.</u> | | | |

Chapel Hill and Hospital

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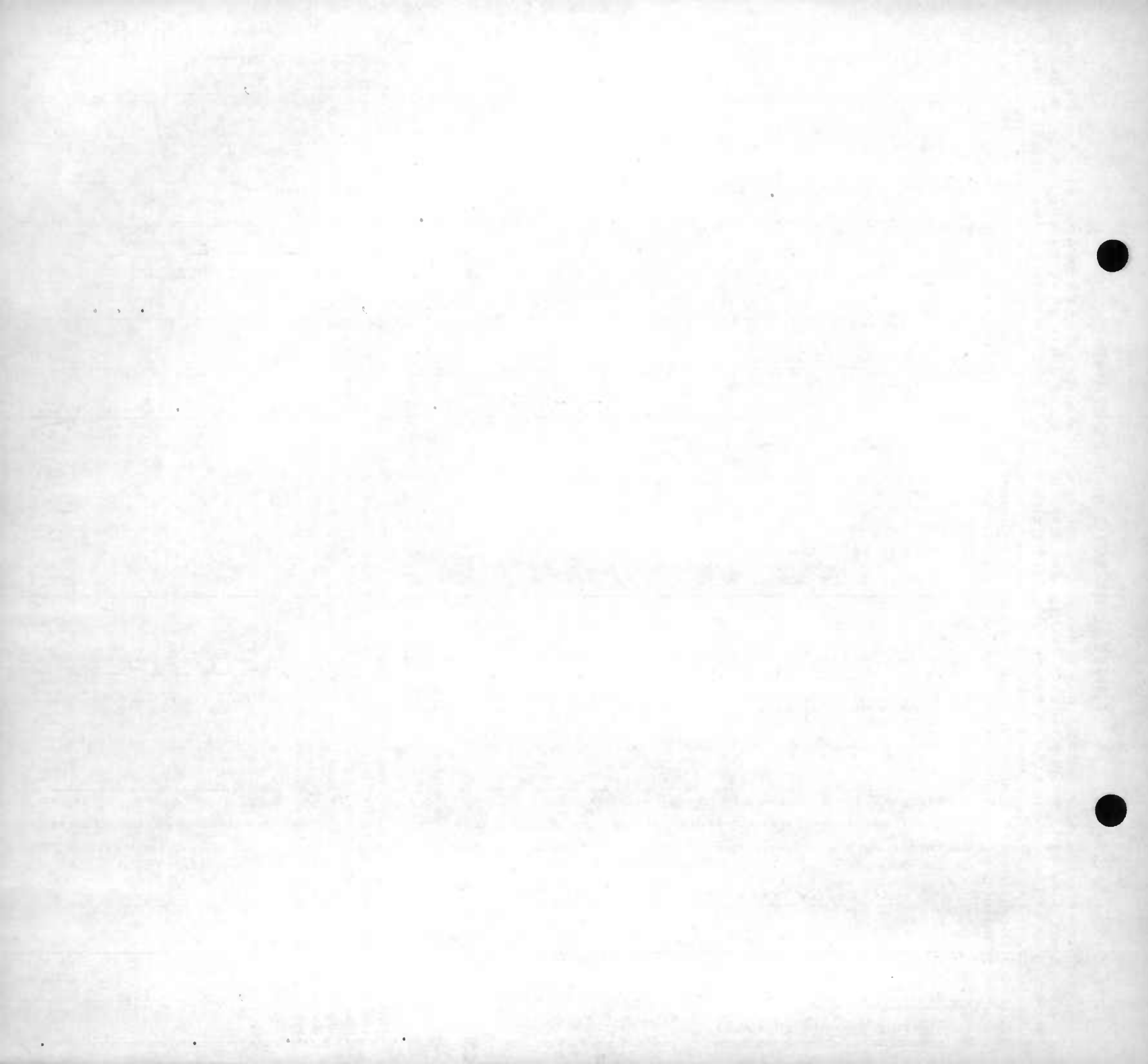
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>65 9554</u> | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|------------------------------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. <u>65 9554</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Henry Joseph Buchter</u> | | 2. DATE AND HOUR OF DEATH <u>September 14, 1965</u> <u>1</u> P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>918 E. 41st Street</u> | | A. STATE <u>Maryland</u> B. COUNTY <u>9-01</u> | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>918 E. 41st Street</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>7/15/1909</u> | 9. AGE (In years last birthday) <u>56</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchmaker</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>August Buchter</u> | | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Concannon</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW 2</u> | | 16. SOCIAL SECURITY NO. <u>212-03-1784</u> | | 17. INFORMANT <u>Mrs. Kathryn Buchter</u> ADDRESS <u>918 E. 41st Street</u> | |
| 18. <u>163X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) <u>Pulmonary carcinoma</u> DUE TO (B) _____ DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>1 yr - 6 mos.</u> | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1, 1965</u> to <u>Sept. 14, 1965</u> , that (I) (we) last saw the deceased alive on <u>Sept. 14, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>J. Willis Guyton</u> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>9/15/65.</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>J. Willis Guyton</u> | | 23D. ADDRESS <u>3961 Greenmount Ave.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>9/17/1965</u> | 24C. NAME of CEMETERY or CREMATORY <u>Oak Lawn Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 17 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>John A. Morgan Inc.</u> ADDRESS <u>3000 E. Baltimore St.</u> | |



| BIRTH NO. 65 9555 | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 9555 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. | | | | | |
| 1. NAME OF DECEASED (Type or Print) EARL H. MARTIN | | | 2. DATE AND HOUR PRONOUNCED DEAD September 14, 1965 10:35 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) St. Agnes Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 404 Rosecroft Terr. | | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH April 4, 1892 | 9. AGE (In years last birthday) 73 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self | | 10B. KIND OF BUSINESS OR INDUSTRY Retired | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME ----- Martin | | | 14. MOTHER'S MAIDEN NAME Jessie ----- | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 070-14-7856 | 17. INFORMANT XXX Zora T. Martin 404 Rosecroft Terrace | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE EXAMINER'S Rudiger Breitenecker, M.D. NAME (Type) | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED September 14, 1965 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 9/17/65 | 23C. NAME of CEMETERY or CREMATORY New Cathedral | | 23D. LOCATION (City, town, or county) (State) Old Frederick Road, Maryland |
| 24A. DATE REC'D BY HEALTH DEPT. SEP 17 1965 | | 24B. NAME OF REGISTRAR Robert E. Finkbeiner | | 24C. FUNERAL DIRECTOR Hubbard Funeral Home 4107 Wilkens Avenue | |

[Faint, illegible signature or stamp]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------|--|
| BIRTH NO. 65 9556 | | | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Lois Carrigan</i> | | | | | | 2. DATE AND HOUR OF DEATH <i>9/14/65</i> <i>1 945 A</i> M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Mercy Hospital</i> | | | | | | A. STATE <i>md</i> B. COUNTY | | | | | |
| (If not in hospital or institution, give street address or location) | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | | | |
| | | | | | | D. STREET ADDRESS (If rural, give location) <i>2663 Wilkens Ave.</i> | | | | | |
| 5. SEX <i>F</i> | | 6. RACE <i>W</i> | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Never married</i> | | 8. DATE OF BIRTH <i>7/19/43</i> | | 9. AGE (In years last birthday) <i>22</i> | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unemployed</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) <i>md.</i> | | | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | | 13. FATHER'S NAME <i>Leo J. Carrigan</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Selma E. Schaher</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | | 16. SOCIAL SECURITY NO. <i>21242-8093</i> | | | | 17. INFORMANT <i>Mrs. Selma Carrigan</i> | | | |
| ADDRESS <i>2663 WILKENS AVE. 21229</i> | | | | 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>201X I</i> | | | | CAUSE OF DEATH <i>Acute respiratory arrest</i> | | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | 19. DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH <i>5 min</i> | | | |
| ANTECEDENT CAUSES | | | | 20. DUE TO | | | | <i>5 1/2 yrs.</i> | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | 21. DUE TO | | | | | | | |
| II | | | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At <input type="checkbox"/> Work | | | |
| 21F. HOW DID INJURY OCCUR? | | | | 22. I certify that (I) (this hospital) attended the deceased from <i>9/8</i> 19 <i>65</i> to <i>9/14</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>9/14/65</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | 23A. SIGNATURE <i>S Lee Robbins</i> | | | |
| 23B. DATE SIGNED <i>9/14/65</i> | | | | 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| M.D. | | | | M.D. | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | | | 24B. DATE <i>9/17/65</i> | | | | 24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral</i> | | | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | | | | 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 17 1965</i> | | | | 25B. NAME OF REGISTRAR <i>Robert E. Robbins</i> | | | |
| 25C. FUNERAL DIRECTOR <i>HUBBARD FUNERAL HOME</i> | | | | ADDRESS <i>4104 WILKENS AVE. 21229</i> | | | | | | | |

1. The first part of the paper is devoted to a general discussion of the problem of the origin of life. It is shown that the problem is one of the most important and interesting in the history of science.

2. The second part of the paper is devoted to a discussion of the various theories of the origin of life. It is shown that the most plausible theory is that of spontaneous generation.

3. The third part of the paper is devoted to a discussion of the evidence in favor of spontaneous generation. It is shown that the evidence is very strong and conclusive.

4. The fourth part of the paper is devoted to a discussion of the objections to spontaneous generation. It is shown that the objections are not valid.

5. The fifth part of the paper is devoted to a discussion of the conclusions of the paper. It is shown that the conclusions are very clear and definite.

6. The sixth part of the paper is devoted to a discussion of the implications of the conclusions of the paper. It is shown that the implications are very important and far-reaching.

7. The seventh part of the paper is devoted to a discussion of the future of the study of the origin of life. It is shown that the study is still in its infancy and that much more work is needed.

8. The eighth part of the paper is devoted to a discussion of the bibliography of the paper. It is shown that the bibliography is very extensive and covers a wide range of subjects.

9. The ninth part of the paper is devoted to a discussion of the acknowledgments of the paper. It is shown that the acknowledgments are very grateful and sincere.

10. The tenth part of the paper is devoted to a discussion of the index of the paper. It is shown that the index is very complete and covers all the subjects mentioned in the paper.

11. The eleventh part of the paper is devoted to a discussion of the conclusion of the paper. It is shown that the conclusion is very clear and definite.

12. The twelfth part of the paper is devoted to a discussion of the appendix of the paper. It is shown that the appendix is very interesting and contains many valuable facts.

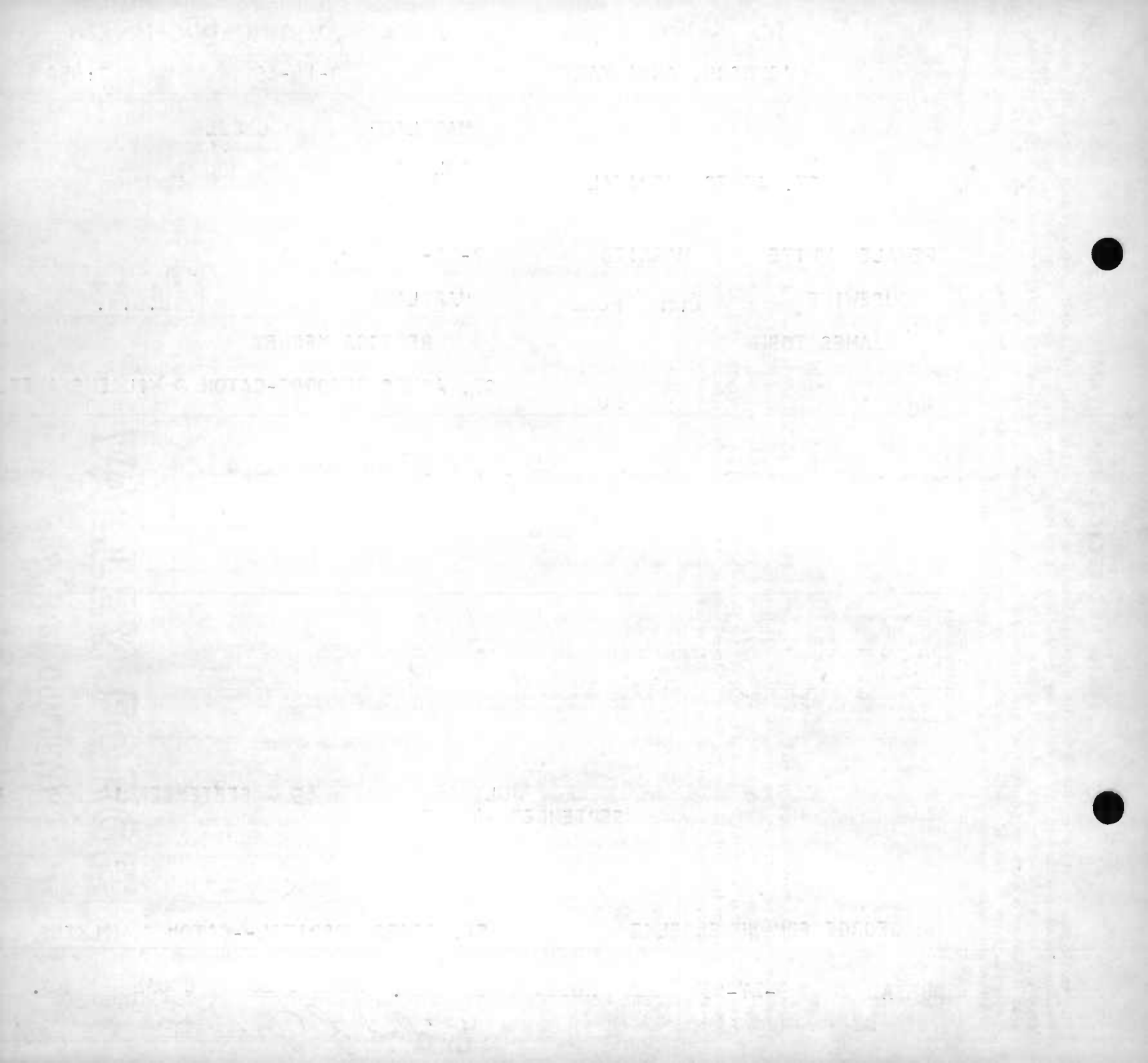
13. The thirteenth part of the paper is devoted to a discussion of the references of the paper. It is shown that the references are very numerous and cover a wide range of subjects.

14. The fourteenth part of the paper is devoted to a discussion of the footnotes of the paper. It is shown that the footnotes are very helpful and contain many interesting facts.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9557 | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|---------------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 65 9557 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) JOHNSON, ANNA MARY | | 2. DATE AND HOUR OF DEATH 9-14-65 2:45A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY CECIL C. CITY OR TOWN (If outside city limits, write RURAL and give township) COLORA RURAL 57-00 D. STREET ADDRESS (If rural, give location) | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 7-11-94 | 9. AGE (In years last birthday) 71 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME JAMES TOSH | | 14. MOTHER'S MAIDEN NAME REBECCA KERNEY | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. NO | | 17. INFORMANT ADDRESS ST. AGNES RECORDS-CATON & WILKENS AVES. #29 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 15371 I | | CAUSE OF DEATH (A) <i>C of Full Blooded to Metastasis April 1965-Sept 65</i> (B) DUE TO (C) | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 08-4-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Simultaneous chest</i> | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) no | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from JULY 16 1965 to SEPTEMBER 14 1965 , that (I) (we) lost saw the deceased alive on SEPTEMBER 14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>George Edmund Engelke</i> M.D. | | | | 23B. DATE SIGNED 9-14-65 | |
| 23C. PHYSICIAN'S NAME (Type) GEORGE EDMUND ENGELKE | | 23D. ADDRESS M.D. ST. AGNES HOSPITAL--CATON & WILKENS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-17-65 | | 24C. NAME of CEMETERY or CREMATORY WEST NOTTINGHAM CEM. | |
| 24D. LOCATION (City, town, or county) (State) NEAR COLORA CECIL MD. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 17 1965 | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>Richard L. Gordie Rising Sun MD.</i> | |



1169
SALES.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. <u>65-9558</u> | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|-----------------------------------------------------------------------------|--|
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) (JOHNNIE) JOHN GALES | | 2. DATE AND HOUR OF DEATH 9/15/65 11:00 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 19-81 | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 412 N. CALHOUN STREET | | | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | | 8. DATE OF BIRTH 6-10-1900 | 9. AGE (In years lost birthday) 65 | If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Mamie Green | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT James Biddle | | ADDRESS 412 N. Calhoun Street | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | (B) DUE TO | | | |
| | | | | (C) | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>August 20</u> 19 <u>65</u> to <u>Sept. 15</u> 19 <u>65</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>Sept. 15</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Herman Kalman Gold</i> M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/15/65 | |
| 23C. PHYSICIAN'S NAME (Type) Herman Kalman Gold | | | | 23D. ADDRESS M.D. Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/18/65 | | 24C. NAME of CEMETERY or CREMATORY Mt Auburn Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 17 1965 | | 25B. NAME OF REGISTRAR <i>Robert E. Fisher</i> | | 25C. FUNERAL DIRECTOR Wm C March | | ADDRESS 928 E. North Ave. | |

170

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|----------------------------------------------------------------------|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 9559 | | | | |
| BIRTH NO. 65 9559 | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) William E. Linderman | | | | | 2. DATE AND HOUR OF DEATH 9-19-65 (SUN) 6 A. M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Balto. Gen'l Hosp | | | | | A. STATE MARYLAND | | | | |
| | | | | | B. COUNTY 23-02 | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE - 212 30 | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 1537 S. CHARLES ST. | | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE | 8. DATE OF BIRTH APR 15-1891 | 9. AGE (In years last birthday) 74 | If Under 1 Yr. Months: Days: Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHIP WOODCAULKER | | | 10B. KIND OF BUSINESS OR INDUSTRY U.S. COAST GUARD SHIPYARD | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME August Linderman | | | | | 14. MOTHER'S MAIDEN NAME Annie Holman | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 09-0146 | | 17. INFORMANT MRS. MARGARET E. STEIN | | | ADDRESS 417 E. LYNN AVE BALTO, MD 21223 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Anterograde Cardiac Disease | | | | | CAUSE OF DEATH (A) DUE TO | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (B) DUE TO | | | | |
| | | | | | (C) DUE TO | | | | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-30 1965 to 9-19 1965, that (I) (we) last saw the deceased alive on 9-19-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Kermit P. Bonovich | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED 9-19-65 | |
| 23C. PHYSICIAN'S NAME (Type) KERMIT P. BONOVICH | | | | | 23D. ADDRESS 1213 Light Street Baltimore, MD | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | 24B. DATE Sept 21-1965 | | 24C. NAME OF CEMETERY or CREMATORY BALTIMORE CEM. | | 24D. LOCATION (City, town, or county) (State) F. NORTH AVE 8A05 ST - BALTO, MD 21213 | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | | 25B. NAME OF REGISTRAR Robert E. Johnson | | | 25C. FUNERAL DIRECTOR CURTIS E. EVANS | | | |
| ADDRESS 1400 S. CHARLES ST. (30) | | | | | | | | | |

CURTIS E. EVANS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65-14696 65 9560 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 9560 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------|--|----------------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | | | |
| (Type or Print) | | | | VIRGINIA ANNE MARTIN | | 9-15-65 | | 10:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE | | B. COUNTY | | | |
| UNIVERSITY HOSPITAL | | | | Md. | | 23-01 | | | |
| BALTIMORE, MD. | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | 1405 RACE STREET | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | |
| F | | CAUC. | | NEVER MARRIED | | 6-7-65 | | 3 8 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| CHILD | | | | | | MARYLAND | | USA | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| BILLY LEE MARTIN | | | | HANNAH WAWARA | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| NO | | | | | | CHART - MOTHER | | | |
| 18. 739.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) ASPIRATION PNEUMONIA | | | | 10 DAYS | |
| ANTECEDENT CAUSES | | | | (B) MULTIPLE CONGENITAL ANOMALIES | | | | LIFE | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) CHROMOSOMAL DEFECT | | | | LIFE | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 7/29/65; 8/5/65 | | REPAIR; GASTROSTOMY (FEEDING) | | NO | | NO | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 7/26 1965 to 9-15 1965, that (2) (we) last saw the deceased alive on 9-15 1965 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | | 9-15-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | |
| M.B. KEELER | | | | UNIVERSITY HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| Burial | | 9/17/65 | | Cedar Hill Cem. | | A.A.C. | | Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | |
| SEP 20 1965 | | Robert E. Farley | | McGilly | | 130E Fort Ave | | | |

WALLACE BOILING

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9561 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9561 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) BOYD, CHARLES JEFF | | 2. DATE AND HOUR OF DEATH 9/15/65 12:40 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARCILAND B. COUNTY BALTIMORE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) PHOENIX 53-80 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4 UNION MEMORIAL HOSP | | D. STREET ADDRESS (If rural, give location) | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 7/8/93 | 9. AGE (In years last birthday) 72 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER | | 10B. KIND OF BUSINESS OR INDUSTRY AGRICULTURE | | 11. BIRTHPLACE (State or foreign country) VIRGINIA | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME JAMES BOYD | | 14. MOTHER'S MAIDEN NAME SALLY A. SCOTT | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK | | 16. SOCIAL SECURITY NO. UNK | | 17. INFORMANT ADDRESS PATIENT | |
| 18. 177X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) carcinoma, prostate, DUE TO (B) w/ extensive metastasis DUE TO (C) acute hgc. pancreatitis and peritonitis | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneum | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (H) (this hospital) attended the deceased from 9/11/65 19 11:00 PM to 12:40 19 9/15 19 65 , that (H) (we) last saw the deceased alive on 12:40 19 9/15 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Robert N. Whitlock | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/15/65 | |
| 23C. PHYSICIAN'S NAME (Type) ROBERT N. WHITLOCK | | 23D. ADDRESS UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE SEPT. 18/1965 | | 24C. NAME OF CEMETERY or CREMATORY POPLAR GROVE CEM. | |
| 24D. LOCATION (City, town, or county) (State) COCKEYSVILLE, MD. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | 25B. NAME OF REGISTRAR John E. Taylor | |
| 25C. FUNERAL DIRECTOR John E. Taylor | | ADDRESS John E. Taylor's Son, Towson, Md. | | | |

UNION FEDERAL HOSPITAL

ROBERT H. WHITELOCK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9562 | |
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| BIRTH NO. 65 9562 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. 65 9562 | | 1. NAME OF DECEASED (Type or Print) Emma Elizabeth Hess | | 2. DATE AND HOUR OF DEATH Sept. 16, 1965 3:20 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Long Green Nursing Home 115 East Melrose Ave. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Long Green D. STREET ADDRESS (If rural, give location) Manor Road | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 2/26/1878 | 9. AGE (In years last birthday) 87 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (State or foreign country) Upper Cross Roads, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Thomas Chenworth | | | 14. MOTHER'S MAIDEN NAME Ellen Cook | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 216-24-5095 | 17. INFORMANT Ralph C. Hess ADDRESS Long Green, Md. | | |
| 18. #22.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardio-vascular disease | | CAUSE OF DEATH (A) Arteriosclerotic cardio-vascular disease (B) Broncho-pneumonia (C) | | INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 2 wks. | |
| II DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from July 23, 1965 to Sept. 16, 1965 , that (I) (we) last saw the deceased alive on Sept. 13, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Lloyd E. Saylor M.D. | | | | 23B. DATE SIGNED 9/16/1965 | |
| 23C. PHYSICIAN'S NAME (Type) Lloyd E. Saylor M.D. | | | 23D. ADDRESS 3902 Greenmount Ave. Balto., Md. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/18/1965 | | 24C. NAME OF CEMETERY or CREMATORY Jarrettsville | |
| 24D. LOCATION Jarrettsville, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Jarrett | | 25C. FUNERAL DIRECTOR Charles E. Kutz Jarrettsville, Md. | | | |

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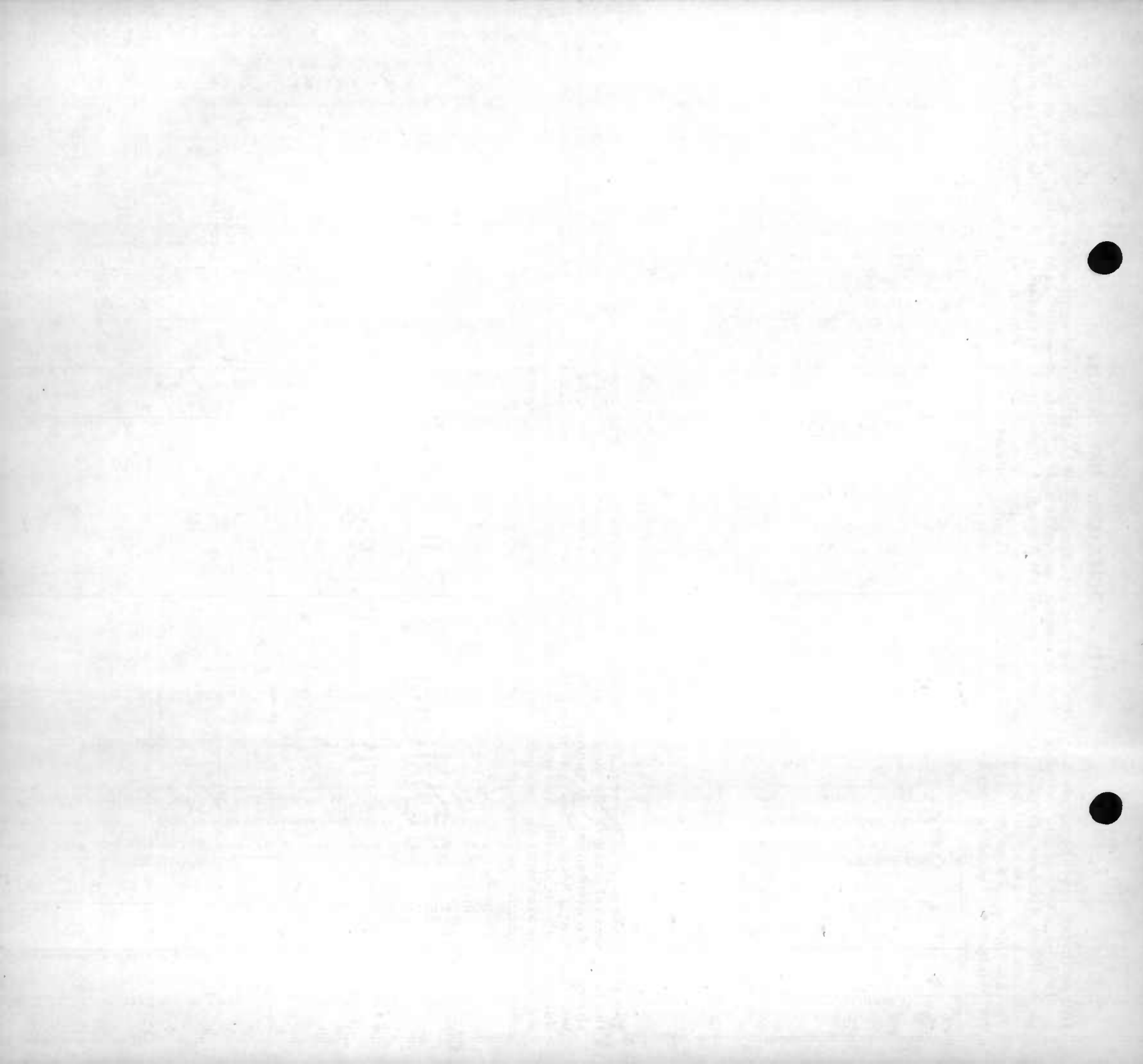
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9563 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9563 | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|---------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>SCHMIDT, MR. JOHN</i> | | 2. DATE AND HOUR OF DEATH <i>9-14-65 245 PM</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>26-03</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>BON SECOURS HOSPITAL</i> | | D. STREET ADDRESS (If rural, give location) <i>5039 ORVILLE AVE</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>CAU.</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i> | 8. DATE OF BIRTH <i>3-27-98</i> | 9. AGE (In years last birthday) <i>67</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED ENGINEER</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>REFRIGERATION</i> | | 11. BIRTHPLACE (State or foreign country) <i>BALTIMORE CITY</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | | 13. FATHER'S NAME <i>LOUIS B. SCHMIDT</i> | | 14. MOTHER'S MAIDEN NAME <i>ANNA M. BERCH</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | 16. SOCIAL SECURITY NO. <i>217-09-5735</i> | | 17. INFORMANT ADDRESS <i>MRS UREIDA MAY SCHMIDT 5039 ORVILLE</i> | |
| 18. <i>58101</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <i>Liver cirrhosis & failure.</i> DUE TO (B) <i>Liver failure.</i> DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>9/14</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>8/17</i> 19 <i>65</i> to <i>9/14</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>9/14</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Artenio Santos</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>9. 14. 65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>ARTENIO SANTOS</i> | | 23D. ADDRESS <i>Bon Secours Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>9/17/65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>GLEN HAVEN</i> | |
| 24D. LOCATION <i>GLENBURNIE MD</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 20 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | |
| 25C. FUNERAL DIRECTOR <i>ULURKH? FUNERAL HOME</i> | | 25D. ADDRESS <i>4210 BELAIR</i> | | | |



September 13, 1965 | 9:39 A. M.

D. STREET ADDRESS (If rural, give location)
877 N. Howard St.

| | |
|----------------|------------------|
| If Under 1 Yr. | If Under 24 Hrs. |
| Months | Days |
| | Hours |
| | Min. |

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

Elizabeth Harding

| | |
|---------------------------|------------------------------|
| 17. INFORMANT | ADDRESS |
| Elizabeth Doyle Williams, | Level Green Trafford, Pa. |

INTERVAL BETWEEN ONSET AND DEATH

Multiple traumatic injuries

(A) _____
DUE TO _____

(B) _____
DUE TO

(C).

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?
YES

| | |
|------------------------------|---------------------------------------------|
| 21C. WHERE DID INJURY OCCUR? | (If in Baltimore City, give exact location) |
|------------------------------|---------------------------------------------|

Howard St..60' south at Armory Pl.

| | |
|----------------------------|--|
| 21F. HOW DID INJURY OCCUR? | |
|----------------------------|--|

Pedestrian struck by auto

22. I certify that I held an Inqu~~ry~~☐ Ins~~pection~~☐ Autopsy☒ and that on this basis, death in my opinion resulted from: Natural causes☐ Accident☒ Suicide☐ Homicide☐ Undetermined manner☐

Russell S. Fisher, M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED _____

9-13-65

23D. LOCATION (City, town, or county) (State)
Irwin, Pa.

ADDRESS

SEP 20

Ullrich Funeral Home 4210 Belair Road.

N 869129650008070

WALLLEY EDRIDGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-----------------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. 65 9565 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9565 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) WINSTON LEON DAUGHERTY | | 2. DATE AND HOUR OF DEATH SEPTEMBER 16, 1965 8:35 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-03 C. CITY OR TOWN (If outside city limits, write RURAL (and give township)) BALTIMORE D. STREET ADDRESS (If rural, give location) 2607 AILSA AVENUE | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 8-17-09 | 9. AGE (In years last birthday) 56 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER | | 10B. KIND OF BUSINESS OR INDUSTRY U.S. GOVERNMENT | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? UNITED STATES | | | | | |
| 13. FATHER'S NAME SOLOMON F. DAUGHERTY | | 14. MOTHER'S MAIDEN NAME CORA HORSEY | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 220-05-9371 | | 17. INFORMANT AVENUE ST. AGNES RECORDS WILKINS AND CATON | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. If means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) Acute Pulmonary Edema DUE TO (B) Acute Myocardial Infarction DUE TO (C) Myocardial Disease | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS CONTRIBUTING OR CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from AUGUST 28 1965 to SEPTEMBER 16 1965, that (X) (we) last saw the deceased alive on SEPTEMBER 16 1965, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Pablo F. Dibos | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/16/65 | |
| 23C. PHYSICIAN'S NAME (Type) PABLO DIBOS | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | 24B. DATE 9/20/65 | 24C. NAME of CEMETERY or CREMATORY LORRAINE PARK CEMETERY | | 24D. LOCATION (City, town, or county) (State) 6 EAST FRANKLIN STREET Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | 25B. NAME OF REGISTRAR Robert E. [Signature] | | 25C. FUNERAL DIRECTOR ADDRESS HUBBARD FUNERAL HOME 4107 WILKENS AVE. | |

WASHINGTON FIELD OFFICE

MEMORANDUM

TO : SAC, NEW YORK

FROM : SAC, NEW YORK

SUBJECT: [Illegible]

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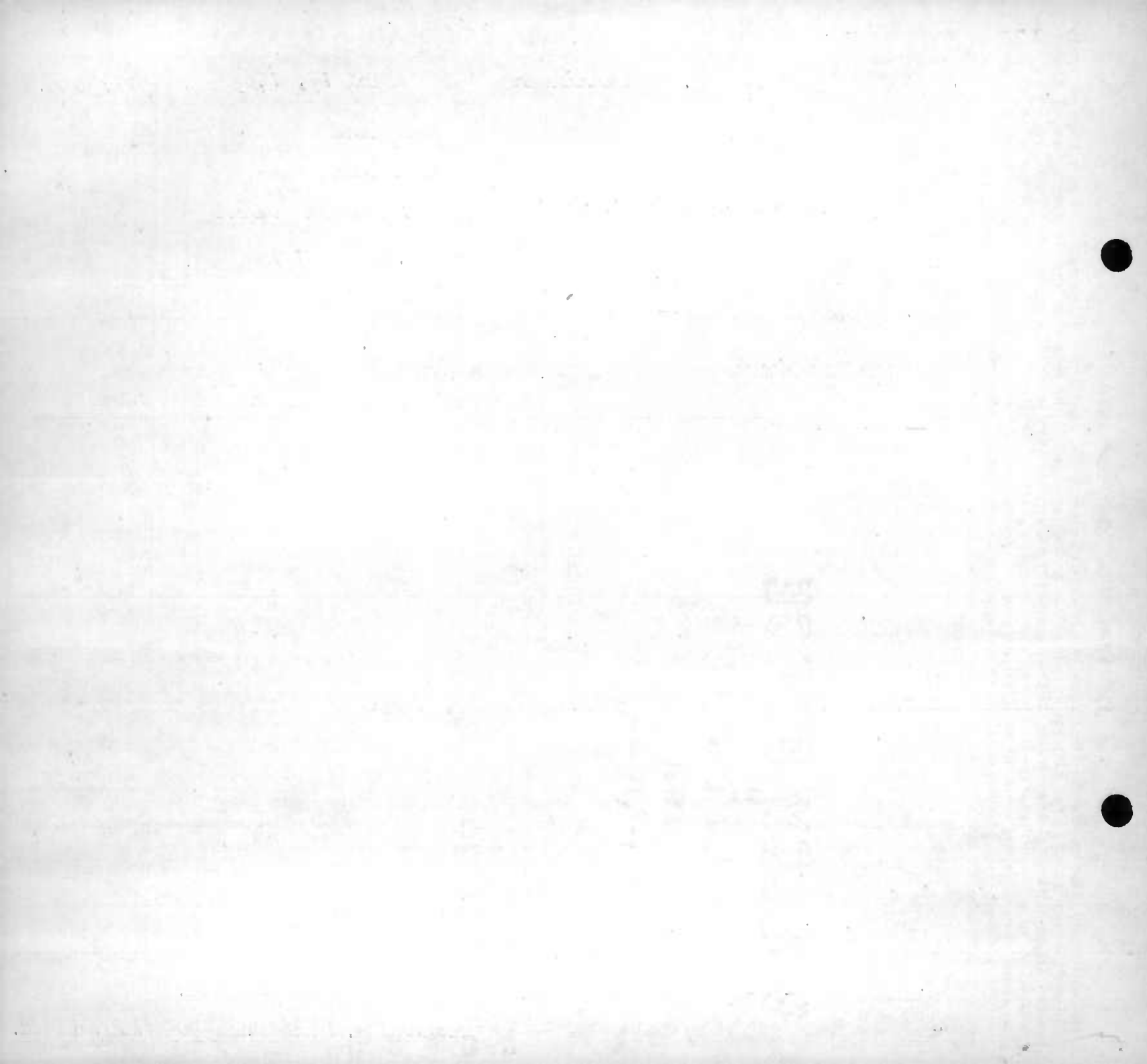
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

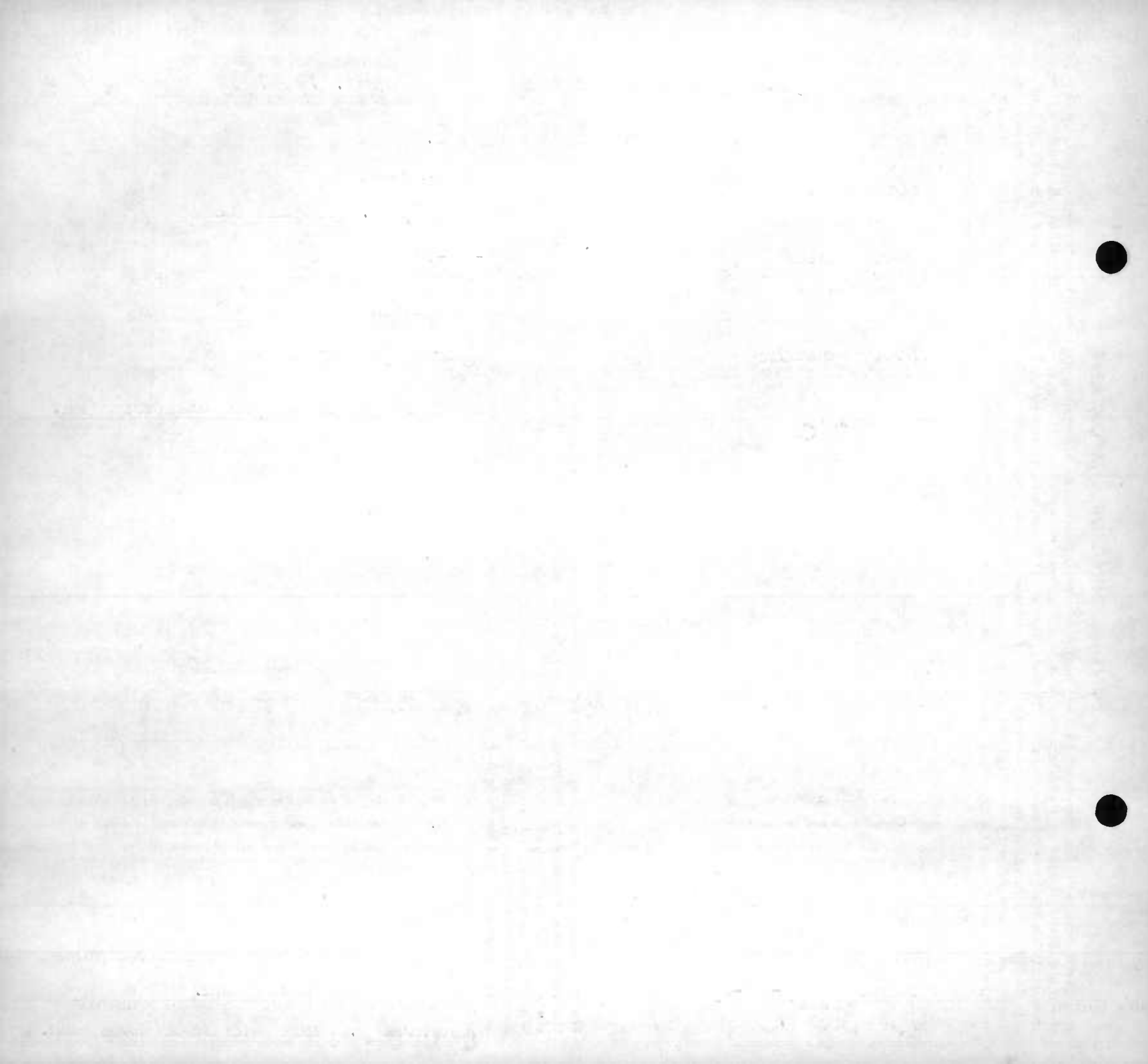
| BIRTH NO. 65 9566 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9566 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------|-----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|------------------------------------------------------------------------|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Grover C. Derringer</i> | | | | 2. DATE AND HOUR OF DEATH <i>Sept 17, 1965 11:30 A.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Gould Convalesarium Home</i> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>26-02</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>4606 Parkwood Avenue</i> | | | |
| 5. SEX <i>male</i> | 6. RACE <i>white</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>widowed</i> | 8. DATE OF BIRTH <i>Nov 20, 1887</i> | 9. AGE (In years last birthday) <i>77</i> | If Under 1 Yr. Months: Days: | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Pressman</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>News-Post</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Henry Derringer</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Adelaide Peregoy</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Mrs Alma Dieringer</i> | | ADDRESS <i>same</i> | |
| 18. <i>422.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Cardio vascular sclerosis</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Scurvity</i> | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH <i>2-3 yrs.</i> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>abdominal aneurysm</i> | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (the hospital) attended the deceased from <i>1963</i> to <i>1965</i> and that (I) (we) last saw the deceased alive on <i>9/15/65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Thomas Graziano</i> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED <i>9/17/65</i> | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>T-J. Graziano</i> | | | | 23D. ADDRESS M.D. <i>2802 Harford Rd 21218</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i> | | 24B. DATE <i>9-20-65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Loudon Park Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 20 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc</i> | | | |
| ADDRESS <i>5305 Harford Rd.</i> | | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9567 | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------|--|
| BIRTH NO. 65 9567 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Clara Eastwood Courtney | | 2. DATE AND HOUR OF DEATH Sept. 17, 1965 6:40 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Melchor Nursing Home | | A. STATE Md. B. COUNTY 12-26 | | | |
| 5. SEX female | | 6. RACE white | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) single | |
| 8. DATE OF BIRTH 7-23-1880 | | 9. AGE (in years lost birthday) 85 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Harry Courtney | |
| 14. MOTHER'S MAIDEN NAME Clara Eastwood | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Vincent Eastwood | | ADDRESS 400 Rosebank Ave. | | | |
| 18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) congestive Heart Failure | | | |
| ANTECEDENT CAUSES | | (B) arteriosclerosis Heart Disease | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Pulmonary Embolism | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from January 10, 1964 to September 17, 1965, that (we) last saw the deceased alive on September 17, 1965 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE Stanley Z. Feltenberg | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9/18/65 | |
| 23C. PHYSICIAN'S NAME (Type) STANLEY Z. Feltenberg | | 23D. ADDRESS 1129 E. Baltimore St - 2 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE 9-20-65 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery | |
| 24D. LOCATION Baltimore, Md. | | 24E. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | | |
| 24F. NAME OF REGISTRAR Robert E. Taylor | | 24G. FUNERAL DIRECTOR Leonard J. Ruck Inc Baltimore, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

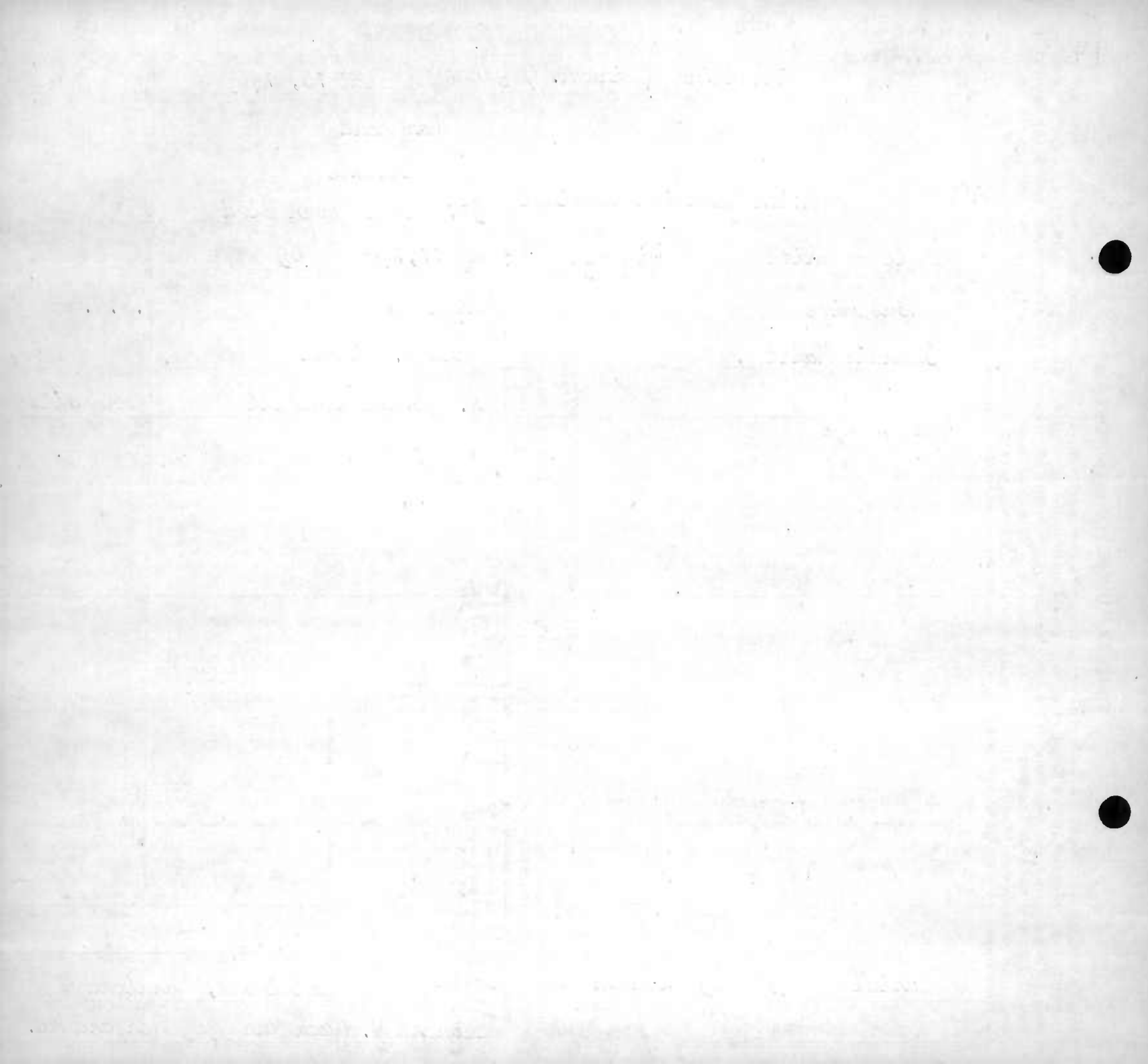
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9568 | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 65 9568 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Niemann, Bruno E. | | 2. DATE AND HOUR OF DEATH September 17, 1965 12:25 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 21206 x 21213 D. STREET ADDRESS (If rural, give location) 5300 Eastbury Ave. Apartment E. | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 1-17-1889 | 9. AGE (In years lost birthday) 76 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Mechanical Engineer | | 11. BIRTHPLACE (State or foreign country) Germany | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Carl Niemann | | 14. MOTHER'S MAIDEN NAME Not known | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 216011446 | | 17. INFORMANT Bruno G. Niemann | |
| 18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Hypertensive cardiovascular disease. DUE TO (B) Multiple abscesses right kidney DUE TO (C) Pulmonary emphysema High blood sugar (diabetes mellitus) | | INTERVAL BETWEEN ONSET AND DEATH | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from September 16, 19 65 to September 17, 19 65 , that (I) (we) last saw the deceased alive on September 17, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE R. Govinda Rao | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED September 17, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) R. Govinda Rao, | | 23D. ADDRESS 1400 N. Caroline St., Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE 9-20-65 | | 24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery | |
| 24D. LOCATION Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Fairbank | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc Baltimore, Md. | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9569 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|-------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 65 9569 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Wilhelmina (Mina K.) Glenn</i> | | 2. DATE AND HOUR OF DEATH <i>Sept 16, 1965 8:50 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i> | | A. STATE <i>Maryland</i> B. COUNTY <i>27-09</i> | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | |
| | | D. STREET ADDRESS (If rural, give location) <i>5210 Loch Raven Blvd</i> | | | |
| 5. SEX <i>female</i> | 6. RACE <i>white</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>widowed</i> | 8. DATE OF BIRTH <i>May 11, 1900</i> | 9. AGE (In years last birthday) <i>65</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>Francis Kalet</i> | | 14. MOTHER'S MAIDEN NAME <i>Anna M. Witzke</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Mr. Edward Krastell</i> ADDRESS <i>Annapolis</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Coronary Occlusion</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>marked Obesity</i> | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>Sept 13 1965</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) _____ | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____ | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____ | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? _____ | | 22. I certify that (I) (this hospital) attended the deceased from <i>Sept 13 1965</i> to <i>Sept 16 1965</i> , that (I) (we) last saw the deceased alive on <i>Sept 13 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | |
| 23A. SIGNATURE <i>James E. White</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>Sept 17/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>James E. White</i> | | M.D. | | 23D. ADDRESS <i>5214 HARFORD RD.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>9/20/65</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Loudon Park Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 20 1965</i> | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Farley</i> | | 25C. FUNERAL DIRECTOR <i>Leonard J. Buck Inc</i> | | | |
| ADDRESS <i>5305 Harford Rd.</i> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9570 | | CERTIFICATE OF DEATH | | Registered No. 65 9570 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MARGARET GENCO | | 2. DATE AND HOUR OF DEATH SEPT. 16, 1965 7:35 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION MONTEBELLO STATE HOSP. | | A. STATE MARYLAND B. COUNTY 26-34 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 6 | | | |
| | | D. STREET ADDRESS (If rural, give location) 4814 Greencroft Rd. | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED NEVER MARRIED WIDOWED (specify) | | 8. DATE OF BIRTH 4/5/01 | 9. AGE (In years lost birthday) 64 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEWING & Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) SICILY, ITALY | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME STEPHEN MALTESE | | 14. MOTHER'S MAIDEN NAME Mary Piacentino | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 218-26-1950 | | 17. INFORMANT HOSP. CHART | |
| 18. 1550 I | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | metastatic Carcinoma | | + 2 yrs | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO sinus Ca (Primary?) | | | |
| | | (B) DUE TO BILE DUCTS? | | | |
| | | (C) | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 28 1965 to Sept. 16 1965 , that (I) (we) lost saw the deceased alive on Sept. 16 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Reuben Guerrero | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/16/65 | |
| 23C. PHYSICIAN'S NAME (Type) Reuben Guerrero M.D. | | 23D. ADDRESS Montebello State Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/20/65 | | 24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214 | | | |

9-25-72 10:15 AM

MARGARET GUNCO

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9571 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9571 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED P. Edmund J. Meskill | | 2. DATE AND HOUR OF DEATH Sept. 17, 1965 1:30 P.M. | |
| 1. NAME OF DECEASED (Type or Print) | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND Western Electric Co., Infirmary | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Western Electric Co., Infirmary | | 5. SEX Male | | 6. RACE White | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH 3-14-1906 | | 9. AGE (in years last birthday) 59 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Expeditor | | 10B. KIND OF BUSINESS OR INDUSTRY Western Elec. Co. | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Edmund J. Meskill | | 14. MOTHER'S MAIDEN NAME Katherine M. Connor | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 220783470 | | 17. INFORMANT Ann M. Meskill | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) DUE TO Acute Cor. Arter. (B) DUE TO Coronary Insufficiency (C) DUE TO A-V. Block | | INTERVAL BETWEEN ONSET AND DEATH Few Minutes. 9 Months. 9 Months | |
| 19. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work [] Not While At Work [] | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from April 15, 1965 to September 17, 1965, that (I) (we) last saw the deceased alive on 9-14-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE William L. Fearing | | 23B. DATE SIGNED 9-17-65 | |
| 23C. PHYSICIAN'S NAME (Type) William L. Fearing | | 23D. ADDRESS 3025 Cedar Road | | 24A. BURIAL CREMATION, REMOVAL (Specify) burial | |
| 24B. DATE 9-21-65 | | 24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | 25B. NAME OF REGISTRAR Robert E. Fearing | | 25C. FUNERAL DIRECTOR Leonard D. Hick Inc. 5305 Harford Rd. #14 | |

V.S. 153

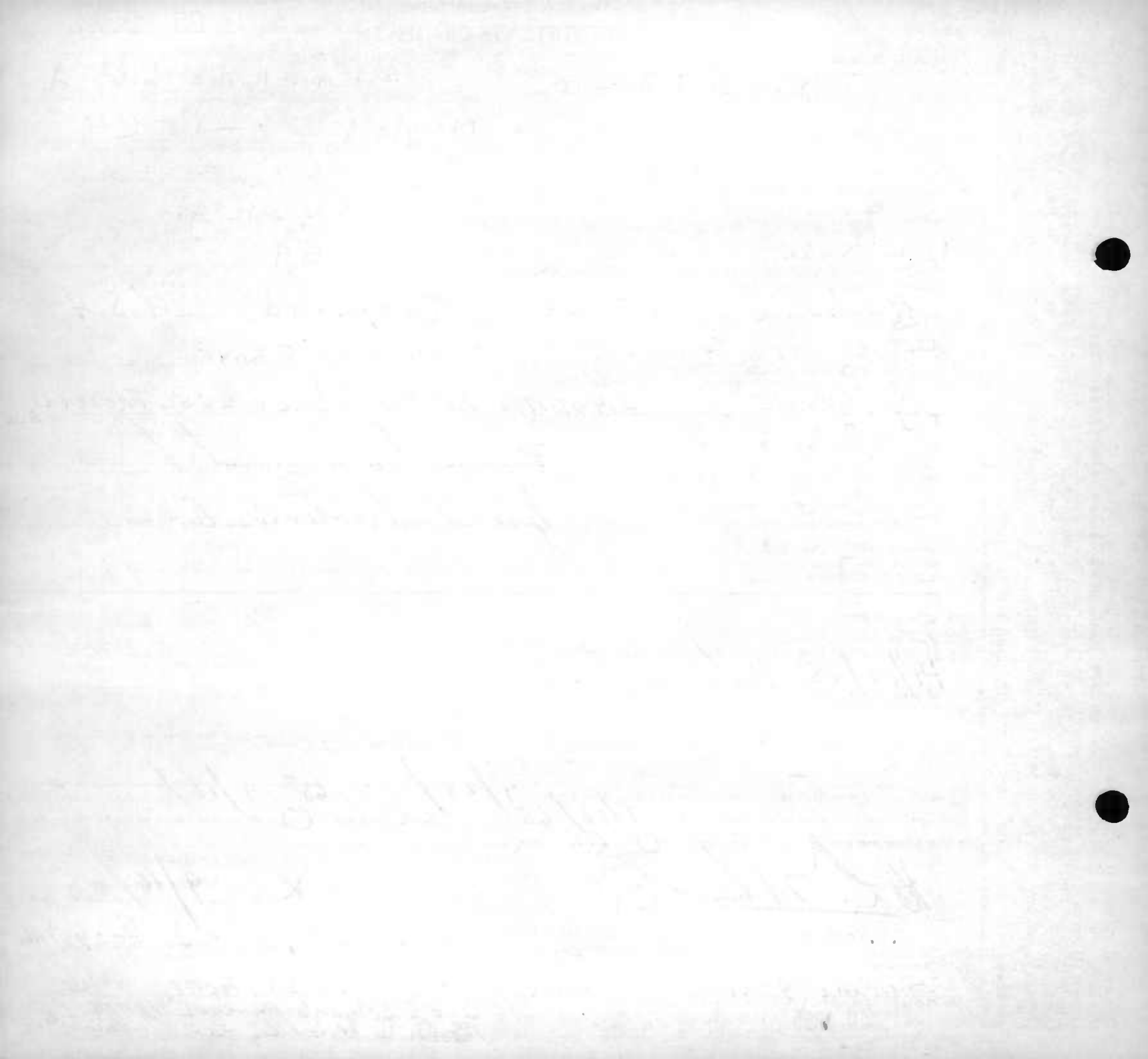
9-27-65

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9572 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9572 | |
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| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) John Schroen | | | |
| 2. DATE AND HOUR OF DEATH September 16, 1965 16:55 A.M. | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University of Md. Hospital Lombard & GREENE STS. Baltimore, Md | | | | A. STATE Maryland B. COUNTY 20-04 | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21223 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 2556 Frederick Ave | | | |
| 5. SEX Male | 6. RACE Cauc. | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH 6-17-06 | 9. AGE (In years lost birthday) 59 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic | | 10B. KIND OF BUSINESS OR INDUSTRY RETIRED | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 13. FATHER'S NAME GEORGE OTTO Schroen | | 14. MOTHER'S MAIDEN NAME Catherine CROVE | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No NONE | | 16. SOCIAL SECURITY NO. 219-07-1792 | | 17. INFORMANT LOTTIE SCHROEN | | ADDRESS 2556 Frederick Ave | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Probable myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerosis | | | | CAUSE OF DEATH (A) Probable myocardial infarction (B) Arteriosclerosis (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 9/14/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Arteriosclerosis | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/29/65 to 9/16/65 , that (I) (we) last saw the deceased alive on 9/16/65 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE H. J. Marter | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/16/65 | |
| 23C. PHYSICIAN'S NAME (Type) H. J. Marter | | | | 23D. ADDRESS University of Md. Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 9-21-65 | | 24C. NAME OF CEMETERY OR CREMATORY London Park | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MD | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | 25B. NAME OF REGISTRAR Robert E. Fink | | 25C. FUNERAL DIRECTOR Geo. L. Schwab ADDRESS 2101 Frederick Ave | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

2 APRIL

STATIONER, BATHING

BATHING 221 AND

THREE DUND STREET

CHURCH HOME AND

FRANK CASHMAN AND THE WHEELER

SCHOOL TEACHERS & CULTURE

TECHNICAL - WASHINGTON

24-11-1914

(ADDITIONAL) INVEST

DEVELOPMENT - 221 AND

FRANK CASHMAN AND THE WHEELER

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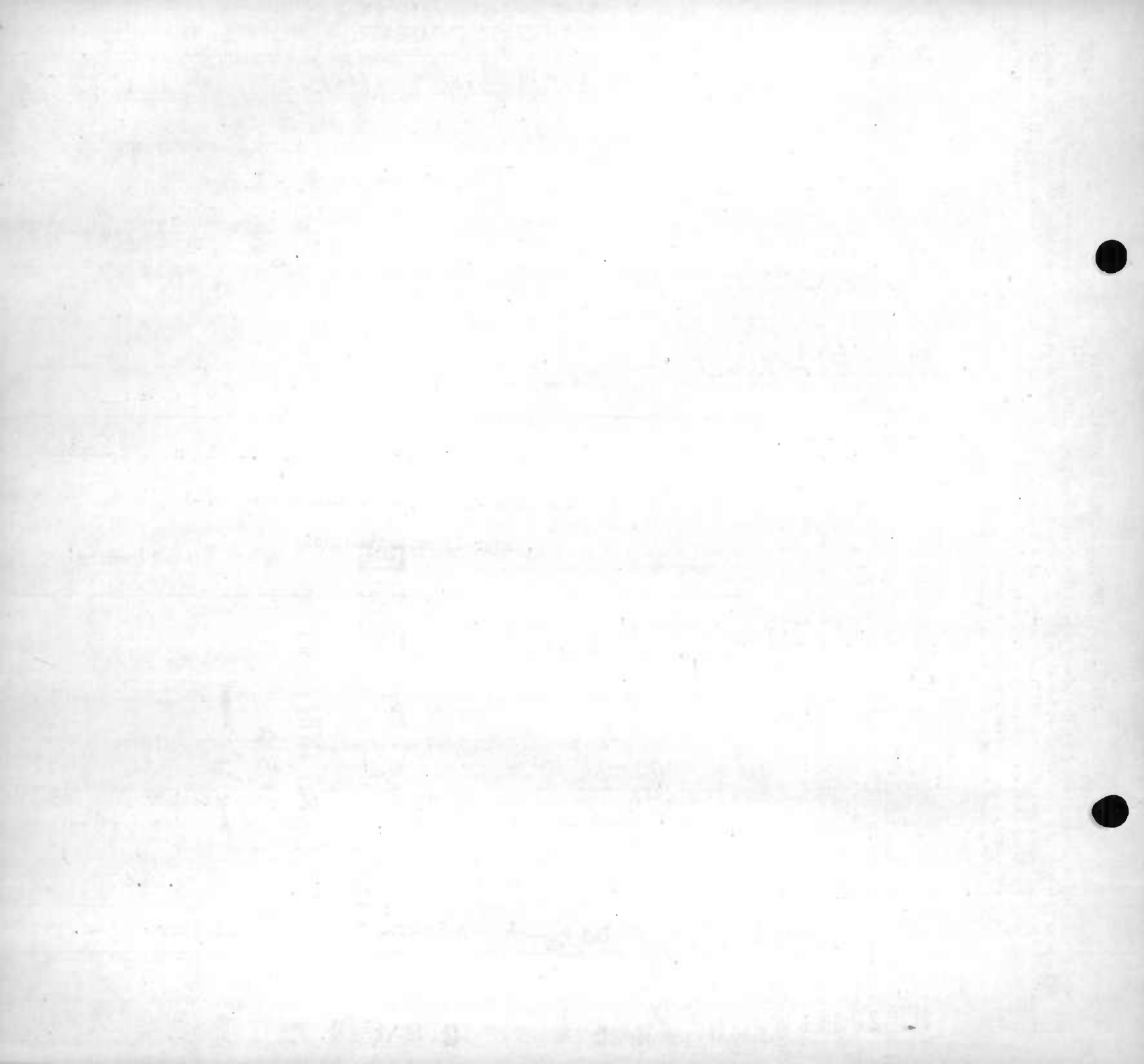
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

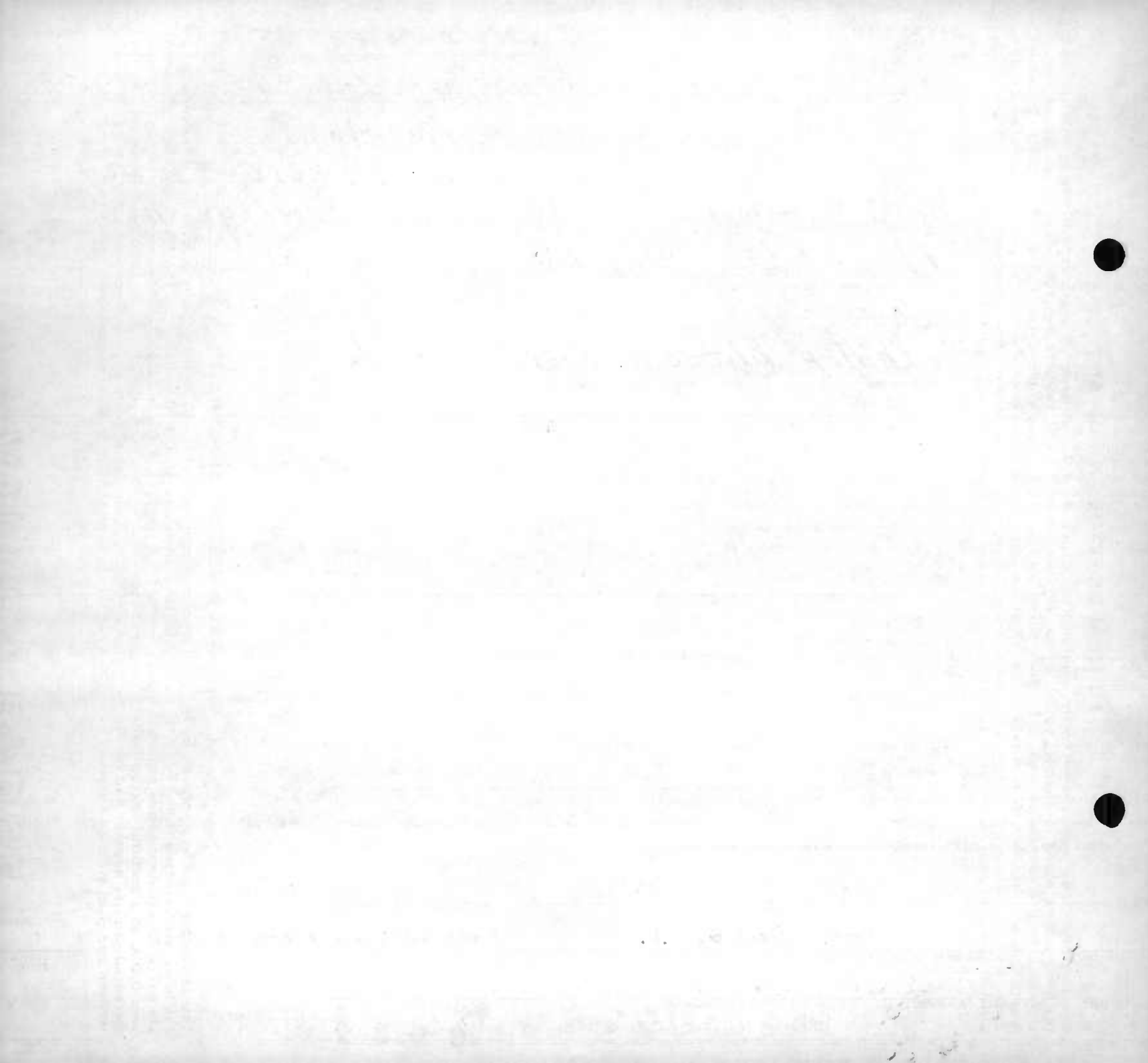
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------|------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------|--|
| BIRTH NO. 65 9574 | | CERTIFICATE OF DEATH | | | | Registered No. 65 9574 | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) SHAMER, Raymond M. | | | | 2. DATE AND HOUR OF DEATH 9/15/65 6:50 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY Balt | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) Franklin St. Hosp | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto Highlands 63-00 | | D. STREET ADDRESS (If rural, give location) 2843 Tenn ave | |
| 5. SEX M | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH Feb 11-1912 | 9. AGE (In years last birthday) 53 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Estimator | | 10B. KIND OF BUSINESS OR INDUSTRY John West Motor Co | | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME Wm F. Shamer | | | | 14. MOTHER'S MAIDEN NAME Edith Fohaty | | 17. INFORMANT Family | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Family | | ADDRESS Same | | | |
| 18. 200.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | (A) DUE TO Malignant lymphoma of liver, spleen | | 2 months | |
| | | | | | | (B) DUE TO messentery and abdominal lymph nodes | | | |
| | | | | | | (C) DUE TO Generalized metastasis | | 2 months | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 27 1965 to September 15 1965, that (I) (we) last saw the deceased alive on Sept 15 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Paul Schonfeld | | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9.16.65 | |
| 23C. PHYSICIAN'S NAME (Type) Paul Schonfeld M.D. | | | | 23D. ADDRESS 2301 Annapolis Rd Baltimore 30 Md. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-18-65 | | 24C. NAME of CEMETERY or CREMATORY Loudon Pk. Cem | | 24D. LOCATION (City, town, or county) (State) Balto 29 Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR | | ADDRESS 237 Patuxent Ave | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

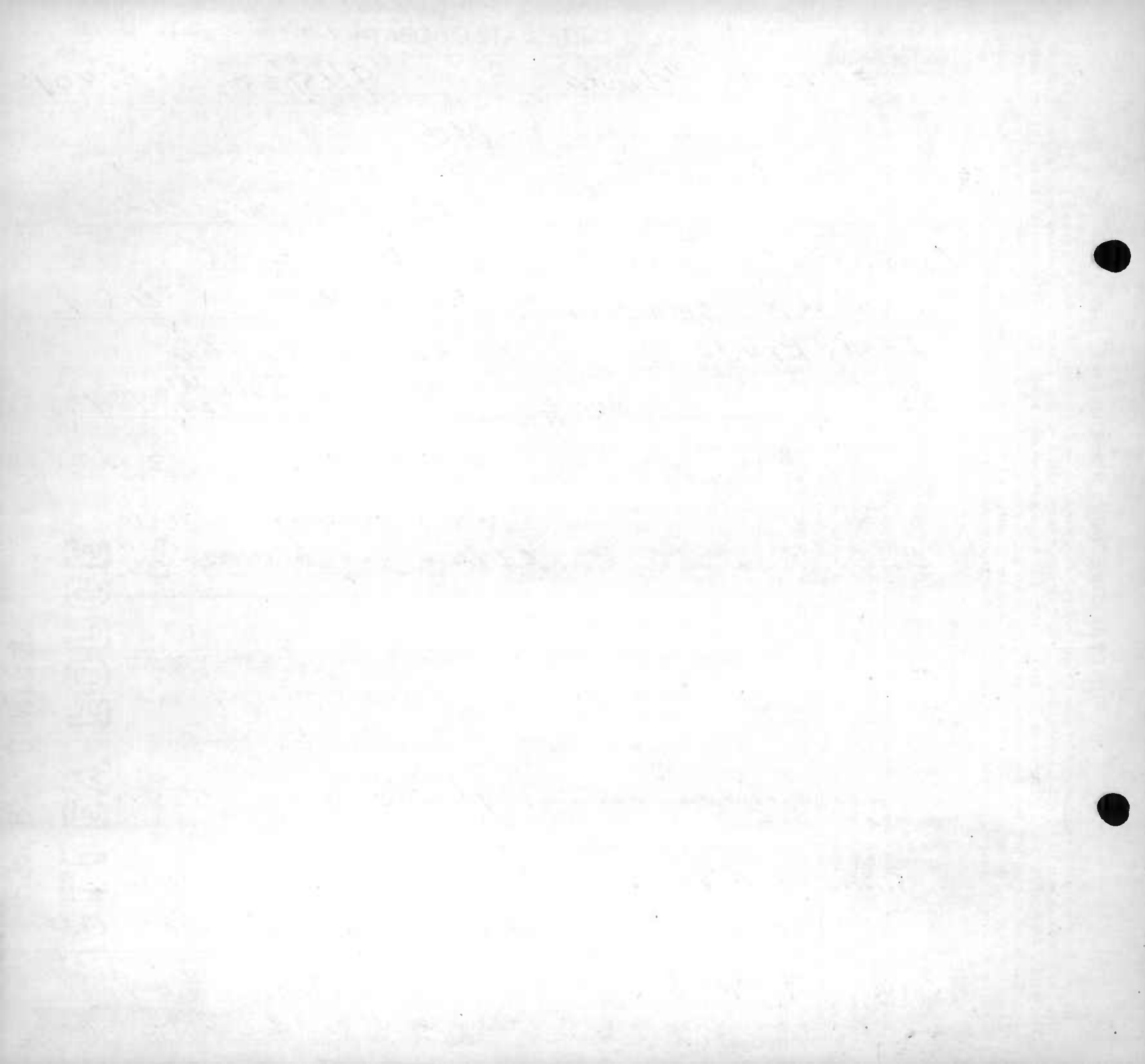
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9575 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 65 9575 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Holmes Blottenberger | | 2. DATE AND HOUR OF DEATH 9-15-65 2:35 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 25-04 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hosp. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #21225 | | | |
| (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location) 3816 Brooklyn Ave. | | | |
| 5. SEX M. | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH 2-4-1904 | 9. AGE (In years last birthday) 61. | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) QA Co. School Comm | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MD. | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME Phillip Blottenberger | | 14. MOTHER'S MAIDEN NAME Hale Mary Remmers | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Family ADDRESS Same | |
| 18. 157X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Carlinoma of pancreas DUE TO 2 metastases. (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES. | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that we (this hospital) attended the deceased from 8-27 19 65 to 9-15 19 65 , that we (we) last saw the deceased alive on 9-15 19 65 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Verner Albertson, M.D. | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-15-65 | |
| 23C. PHYSICIAN'S NAME (Type) Verner Albertson, M.D. | | 23D. ADDRESS South Baltimore General Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9-18-65 | 24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cem. | | 24D. LOCATION (City, town, or county) (State) Baltimore Md | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | 25B. NAME OF REGISTRAR Robert E. Taylor | 25C. FUNERAL DIRECTOR McCully & Co. | | ADDRESS 237 Potters Lane | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 65 9576 | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| BIRTH NO. 65 9576 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) ETHEL N. HELMUTH | | 2. DATE AND HOUR OF DEATH 9/15/65 5:40 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 36 FRANKLIN SQUARE HOSP. | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 21-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1221 WASHINGTON BLVD. | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH 12/18/00 | 9. AGE (In years lost birthday) 64 | If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Balt. Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JAMES KINSEY | | | | 14. MOTHER'S MAIDEN NAME Laura Sinclair | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Husband John Helmuth | | ADDRESS 1221 Washington Blvd. | |
| 18. 5-92X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | CAUSE OF DEATH (A) DUE TO Uremia (B) DUE TO Chronic glomerulonephritis (C) Anemia sec to uremia | | INTERVAL BETWEEN ONSET AND DEATH 2 mos 3 mos. 2 mos. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION O | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/11/65 19 to 9/15/65 19 that (I) (we) last saw the deceased alive on 9/15/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Silvio B. Munesser | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/15/65 | |
| 23C. PHYSICIAN'S NAME (Type) Silvio B. Munesser | | | | 23D. ADDRESS 101 Calhoun St. Balt. Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/20/65 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore National | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Walter F. Ford Home Proff. & Stricker | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9577 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|----------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. 65 9577 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MARTHA H. GABLE | | 2. DATE AND HOUR OF DEATH SEPT 15, 1965 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE CO. 16 VIRGINIA AVE 5300 | |
| FULL NAME OF HOSPITAL OR INSTITUTION GOULD CONVALESCENT HOME | | (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location) | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH FEB 12, 1885 | 9. AGE (In years last birthday) 80 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY HOMEMAKER. | | 11. BIRTHPLACE (State or foreign country) LANCASTER CO. PENNSYLVANIA | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | | 12. CITIZEN OF WHAT COUNTRY? USA. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No. | | 16. SOCIAL SECURITY NO. 211-18-8887 | | 17. INFORMANT GEORGE Y. GABLE. 16 VIRGINIA AVE. BALTO. MD. | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH | | (A) Atherosclerosis DUE TO | | INTERVAL BETWEEN ONSET AND DEATH many years. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Cardiovascular DUE TO | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) Desire Probable Terminal Infection. | | inst. | |
| II MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec 1963 19 to 9-15 19 65 , that (I) (we) last saw the deceased alive on 9-7 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE John C. Hyle | | | | 23B. DATE SIGNED 9-16-65 | |
| 23C. PHYSICIAN'S NAME (Type) JOHN C. HYLE | | 23D. ADDRESS 7527 Belair Rd | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE SEPT 18/1965 | | 24C. NAME of CEMETERY or CREMATORY MILLERSVILLE MELBOURITE CEM. | |
| 24D. LOCATION (City, town, or county) (State) LANCASTER. CO. PENNSYLVANIA | | 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Fairbairn | | 25C. FUNERAL DIRECTOR Logan's Funeral Home. 7401 Belair Rd. | | | |

BIRTH NO.

65 9578

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65 9578

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

FRANKLIN

COLEMAN

2. DATE AND HOUR PRONOUNCED DEAD

9/16/65

3:23 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

1515 Riggs Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1515 Riggs Ave.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

January 8, 1920

9. AGE (In years
last birthday)

45

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

Sykesville Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Jenkins F. Coleman

14. MOTHER'S MAIDEN NAME

Ella ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

213-12-3264

17. INFORMANT

ADDRESS

Jenkins F. Coleman 834 Franklinton Rd

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) ~~Advanced decomposition-no anatomically~~
determinable cause of death

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/17/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Sept. 18/65

23C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cem.

23D. LOCATION

(City, town, or county)

Balto. Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

SEP 20 1965

24B. NAME OF REGISTRAR

Robert E. Fabel

24C. FUNERAL DIRECTOR

Williams Funeral Home 319 N. Howard St.

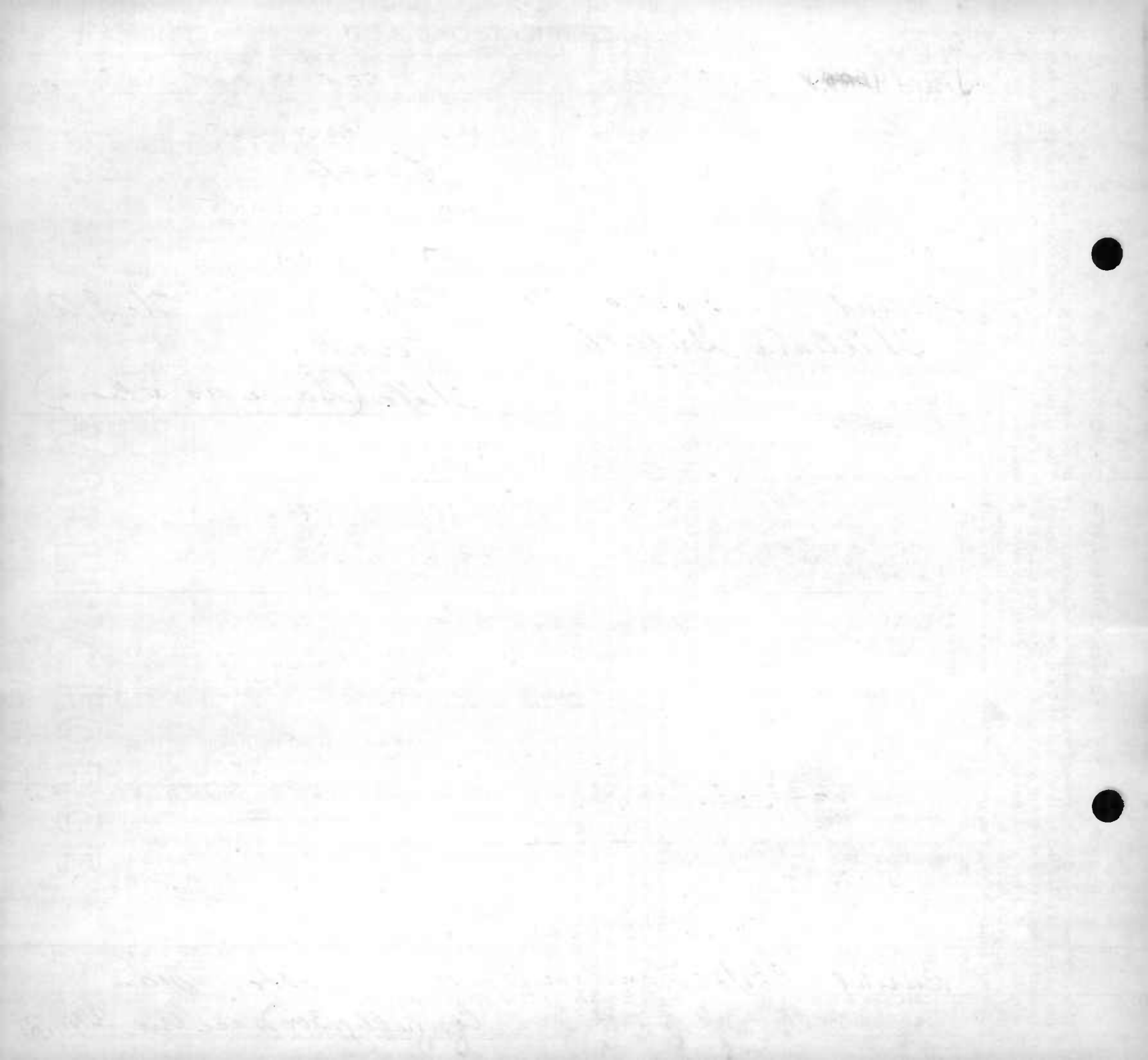
ADDRESS

WALTHEM HONGKONG

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

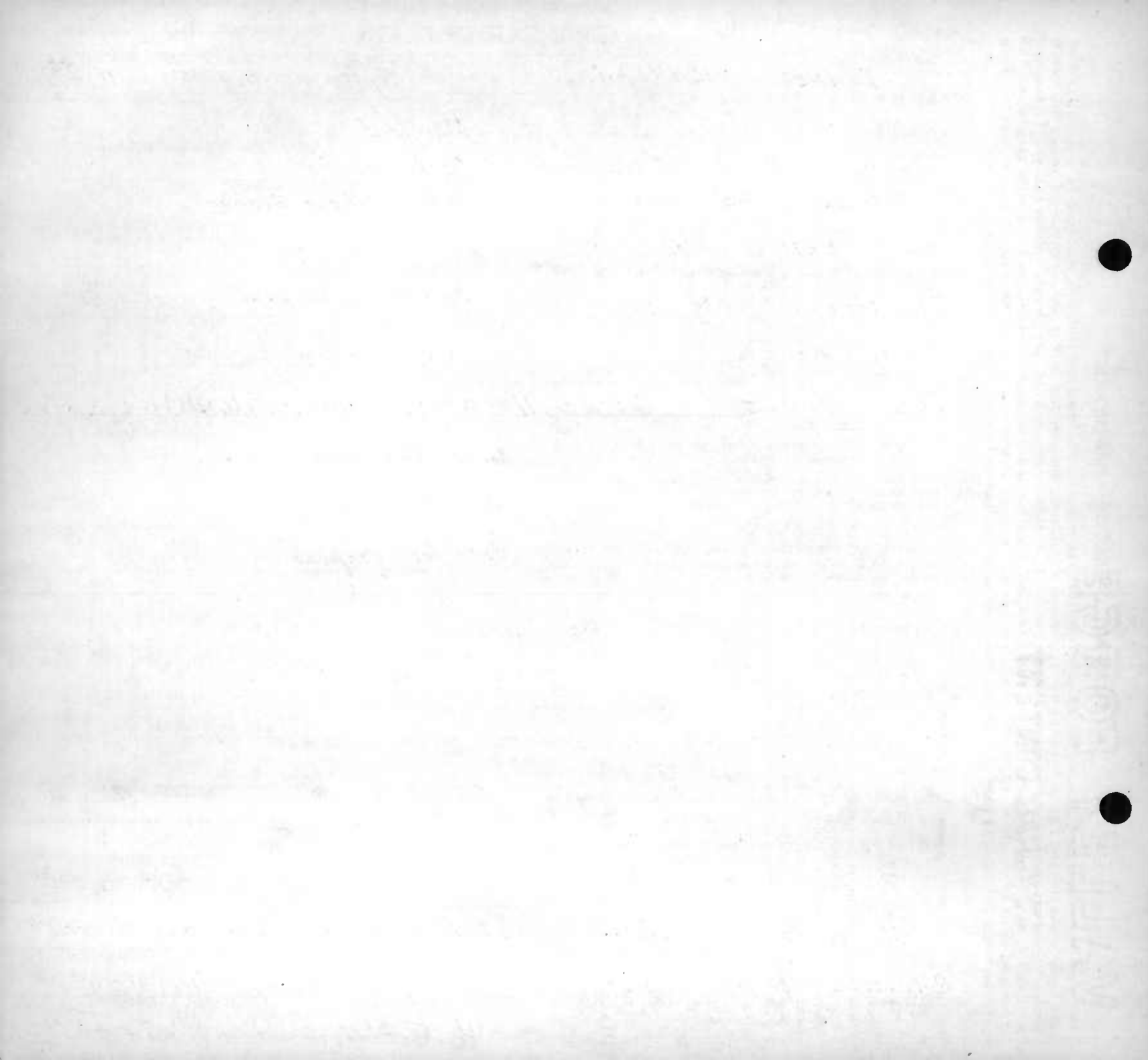
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|---------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------|----------------------------------|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 9579 | | | | |
| BIRTH NO. 65 9579 | | | | | M.E. CASE NO. 65 9579 | | | | |
| 1. NAME OF DECEASED (Type or Print) JOSEPH HARRY GRIFFITH | | | | | 2. DATE AND HOUR OF DEATH SEPT 17, 1965 1 A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTIMORE C. CITY OR TOWN (If outside city limits, write RURAL and give township) Essex 93-00 D. STREET ADDRESS (If rural, give location) 401 VOGTS LANE | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M | 8. DATE OF BIRTH 4/27/91 | 9. AGE (In years lost birthday) 74 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | | 10B. KIND OF BUSINESS OR INDUSTRY Balto Cold Storage Co | | 11. BIRTHPLACE (State or foreign country) Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME William Griffith | | | | | 14. MOTHER'S MAIDEN NAME Unk. | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Wife (Same as above) | | | | |
| 18. I 181.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (A) UREMIA DUE TO (B) RECURRENT CARCINOMA DUE TO (C) OF BLADDER | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that the (this hospital) attended the deceased from 9/1/1965 to 9/17/1965, that we (we) last saw the deceased alive on 9/16/1965 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Stanley Friedler | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED 9/17/65 | |
| 23C. PHYSICIAN'S NAME (Type) STANLEY FRIEDLER | | | | | 23D. ADDRESS M.D. SINAI HOSP. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/1/65 | | 24C. NAME OF CEMETERY or CREMATORY Landon Park | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | | 25B. NAME OF REGISTRAR Robert E. Fisher | | 25C. FUNERAL DIRECTOR ADDRESS Connelly 300 Wace Ave, Balto, 21 | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9580 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9580 | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------------------------------|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|-----------------------------------------------------------------------------|-----------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) LAHNER, JOHN J. | | | | 2. DATE AND HOUR OF DEATH September 17, 1965 11 50 PM | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital of Maryland Baltimore, Md. 21216 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 19-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 23 D. STREET ADDRESS (If rural, give location) 1716 Wilkens Avenue | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 6-27-1891 | 9. AGE (In years last birthday) 74 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur | | 10B. KIND OF BUSINESS OR INDUSTRY BUS | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.I | | 16. SOCIAL SECURITY NO. 213-10-2491 | | 17. INFORMANT Mary P. Lahner ADDRESS 1716 Wilkens Ave | | | |
| 18. 450.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Aortic thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized toxemia Lost leg gangrene | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerosis | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION 9-13-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Embolism of aorta, iliac & femoral arteries | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from September 11 1965 to September 17 1965 , that (I) (we) last saw the deceased alive on September 17 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 11 50 PM | | | | | | | |
| 23A. SIGNATURE Manuel G. Fontanilla M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED Sept. 17, 1965 | | | |
| 23C. PHYSICIAN'S NAME (Type) Manuel G. Fontanilla M.D. | | | | 23D. ADDRESS Lutheran Hospital - Baltimore, Md. 21216 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/21/65 | | 24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE RECEIVED BY HEALTH DEPT. SEP 20 1965 | | 25B. NAME OF REGISTRAR Robert E. ... | | 25C. FUNERAL DIRECTOR Wigman Funeral Home Pratt & Strickland | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9581 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9581 | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) BETTIE MONROE | | | | 2. DATE AND HOUR OF DEATH 9-13-65 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME HOSP. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 3-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1311 E. BALTIMORE ST. | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 2-3-1894 | 9. AGE (In years last birthday) 71 | If Under 1 Yr. Months Days If Under 24 Hrs. Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK | | 10B. KIND OF BUSINESS OR INDUSTRY RESTAURANT | | 11. BIRTHPLACE (State or foreign country) VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Wm. BRYANT | | | | 14. MOTHER'S MAIDEN NAME MALEY COFFEY | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Billie Jordan - 1824 E. Lombard St. | | ADDRESS | |
| 18. 422.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic C.V.D. with acute heart failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Generalized arteriosclerosis | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH Few Hours 10 years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None | | | | | | | |
| 19A. DATE OF OPERATION None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None | | 20A. AUTOPSY? (Yes or No) None | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner) No accident | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) None | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? No Injury | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Nov 7 1963 to Aug 27 1965 , that (I) (we) last saw the deceased alive on Aug 27 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE J. M. Miller M.D. | | | | 23B. DATE SIGNED Sept 16, 1965 | | 23C. PHYSICIAN'S NAME (Type) J. M. MILLER M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | | 24B. DATE 9-17-65 | | 24C. NAME OF CEMETERY OR CREMATORY MT. CARMEL CEM. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | | | 25B. NAME OF REGISTRAR R. E. F. F. F. | | 25C. FUNERAL DIRECTOR Stanley Miller, 2334 Jefferson St. | |
| 26A. ADDRESS BALTO., Mo. | | | | 26B. ADDRESS 2334 Jefferson St. | | | |

Directorate of C.V.D.
and Civil Administration
Prescribed the Western Region

21-10-62

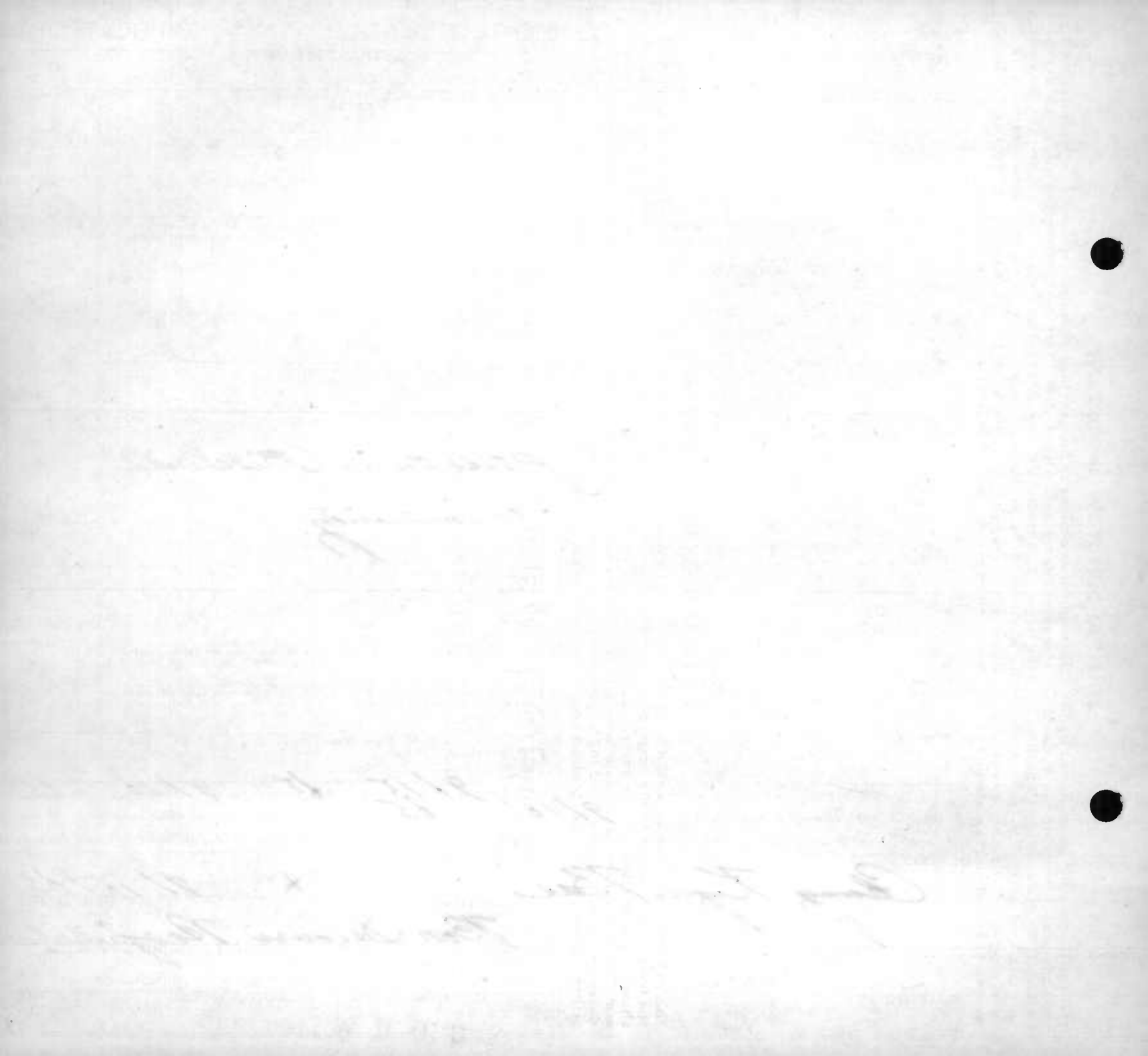
Mr. J. S. S. S. S.
Mr. J. S. S. S. S.

J. M. Miller
1813 & 1814
✓ Mr. J. S. S. S. S.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

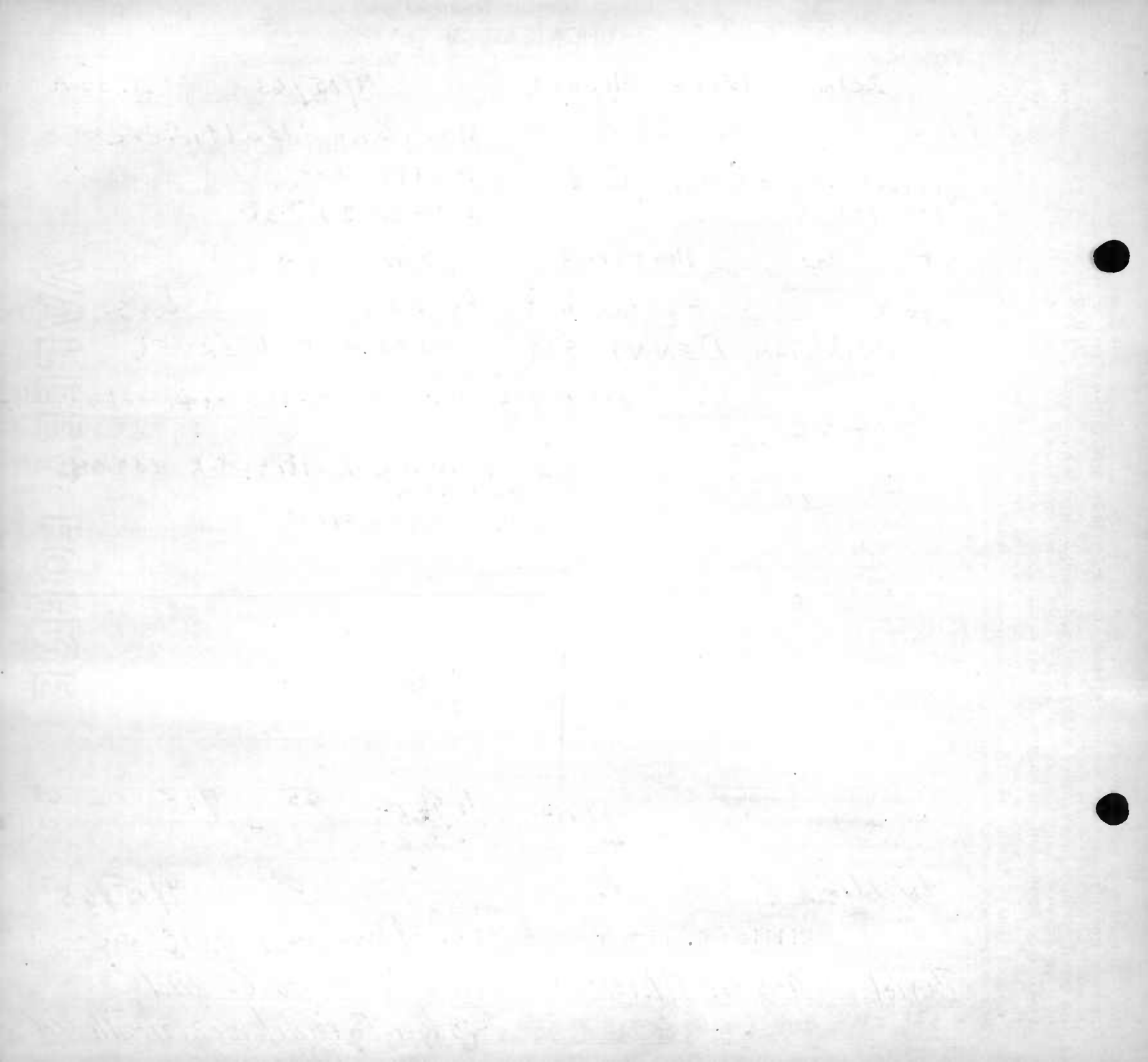
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9582 | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|--------------------------------------------------------------------------|-------------------------------------------------------------------------|
| BIRTH NO. 65 9582 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) GREGORY LEE CRAFT | | 2. DATE AND HOUR OF DEATH 9-16-65 11:10 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 7-6-07 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION BON SECOURS HOSPITAL | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) 737 S. OLDHAM ST. | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 9/15/65 | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 1 4 55 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A | | 13. FATHER'S NAME MOIELLE CRAFT | | 14. MOTHER'S MAIDEN NAME BETTY SUE HOLBROOK | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mr. Moielle Craft - 737 S. Oldham St. | |
| 18. 762.5T | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) Asphyxia (Bicard) DUE TO | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Prematurity DUE TO | | | |
| | | (C) | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/15 19 65 to 9/16 19 65 , that (I) (we) last saw the deceased alive on 9/16 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Chang Kyun Bae | | | | 23B. DATE SIGNED 9/16/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS Bon Secours Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-18-65 | | 24C. NAME of CEMETERY or CREMATORY COLESON CEM. | |
| 24D. LOCATION (City, town, or county) (State) WHITESBURG, KENTUCKY | | 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR ADDRESS Shelby Allen - 2334 Jefferson St. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|--------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------------------------|------------------------------------------|
| BIRTH NO. 65 9583 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9583 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Zelma E. VIRA Allport | | 2. DATE AND HOUR OF DEATH 9/15/65 4:30 A M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University of Maryland Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 220 W. 27th St | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 2/2/15 | 9. AGE (In years last birthday) 50 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook | | 10B. KIND OF BUSINESS OR INDUSTRY Restaurant | | 11. BIRTHPLACE (State or foreign country) Penn | 12. CITIZEN OF WHAT COUNTRY? U.S. |
| 13. FATHER'S NAME WILLIAM DENNY SR. | | 14. MOTHER'S MAIDEN NAME SARAH R. WEAVER | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 198-18-7324 | | 17. INFORMANT MRS. BRASHEARS 3447 ROLAND AVE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E953X | | CAUSE OF DEATH (A) Erythema multiforme DUE TO baillosa (B) Drug Reaction DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 15 days | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/4 19 65 to 9/15 19 65, that (I) (we) lost saw the deceased alive on 9/15 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE William C. Wimmer | | M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/15/65 | |
| 23C. PHYSICIAN'S NAME (Type) William C. Wimmer | | 23D. ADDRESS U.N. of Md. Hosp. Balt. Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-18-65 | | 24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park | |
| 24D. LOCATION Baltimore Co Md | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | 25B. NAME OF REGISTRAR Robert E. Finkbeiner | | 25C. FUNERAL DIRECTOR Bridger Funeral Home | |
| | | | | ADDRESS 3631 Falls Rd | |



BIRTH NO.

65 9584

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65 9584

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES MYERS, Jr.

2. DATE AND HOUR PRONOUNCED DEAD

9/18/65 9:40 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

Baltimore

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Union Memorial Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

433 Schwartz Ave.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

Aug. 16, 1918

9. AGE (In years
last birthday)

47

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Machine Operator

10B. KIND OF BUSINESS OR INDUSTRY

Western Electric

11. BIRTH PLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Chas. Myers, Sr.

14. MOTHER'S MAIDEN NAME

Bertha Smart

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

W.W.II

16. SOCIAL
SECURITY NO.

212-22-1166

17. INFORMANT

Sinie Myers - 433 Schwartz Ave

18. 420.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Acute myocardial infarction
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/18/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/23/65

23C. NAME OF CEMETERY or CREMATORY

Balti. West

23D. LOCATION

Balti. Md.

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

SEP 20 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Wm. J. Chastain, Jr. 1701 Mt. Cullish St
Balti. Md.

ADDRESS

WALHEMPTON

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. 65 9585 | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| <div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. <i>Dr SPITZ medical examiner released body</i></p> <p>M.E. CASE NO. <i>65</i></p> <p>1. NAME OF DECEASED (Type or Print) <i>Mrs Katherine M Heaps</i></p> </div> <div> <p>CERTIFICATE OF DEATH</p> <p>2. DATE AND HOUR OF DEATH <i>9 Sept. 16, 1965 3:15 PM M.</i></p> </div> </div> | | | | | |
| <p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p><i>711 West 34th St</i></p> | | | <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <i>Maryland</i> B. COUNTY <i>13-86</i></p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i></p> <p>D. STREET ADDRESS (If rural, give location) <i>711 West 34th St</i></p> | | |
| <p>5. SEX <i>F</i></p> | <p>6. RACE <i>W</i></p> | <p>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i></p> | <p>8. DATE OF BIRTH <i>7-5-1905</i></p> | <p>9. AGE (In years last birthday) <i>60</i></p> | <p>10. Under 1 Yr. Months: Days: Hours: Min. <i>II Under 24 Hrs. Min.</i></p> |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i></p> | | <p>10B. KIND OF BUSINESS OR INDUSTRY</p> | | <p>11. BIRTHPLACE (State or foreign country) <i>Cockeysville Md.</i></p> | <p>12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i></p> |
| <p>13. FATHER'S NAME <i>James W Williams</i></p> | | | <p>14. MOTHER'S MAIDEN NAME <i>Ida Elizabeth Williams</i></p> | | |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> | | <p>16. SOCIAL SECURITY NO. <i>216-36-6443</i></p> | <p>17. INFORMANT <i>Mr EARL HEAPS</i></p> | | <p>ADDRESS</p> |
| <p>18. <i>45-0-01</i></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> | | | <p>CAUSE OF DEATH</p> <p>(A) DUE TO <i>Congestive Heart Failure</i></p> <p>(B) DUE TO <i>Atherosclerosis</i></p> <p>(C) _____</p> | | <p>INTERVAL BETWEEN ONSET AND DEATH</p> <p><i>8 mo.</i></p> <p><i>8 mo</i></p> |
| <p>19A. DATE OF OPERATION <i>9-20-65</i></p> <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> <p>20A. AUTOPSY? (Yes or No)</p> <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p> | | | | | |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p> | | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> | | <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> | |
| <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p> | | <p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> | | <p>21F. HOW DID INJURY OCCUR?</p> | |
| <p>22. I certify that (I) (the hospital) attended the deceased from <i>Sept 1</i> 19 <i>65</i> to <i>Sept 16</i> 19 <i>65</i>, that (I) (we) last saw the deceased alive on <i>Sept 16</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) view the body after death.</p> | | | | | |
| <p>23A. SIGNATURE <i>Alan B Cohen</i></p> <p>23B. DATE SIGNED <i>Sept 16, 1965</i></p> | | | | <p>M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/></p> | |
| <p>23C. PHYSICIAN'S NAME (Type) <i>Alan B Cohen</i></p> | | <p>23D. ADDRESS <i>Union Memorial Hospital</i></p> | | | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i></p> | | <p>24B. DATE <i>9-20-65</i></p> | | <p>24C. NAME OF CEMETERY or CREMATORY <i>BELAIR MEM GARDENS BELAIR MD</i></p> | |
| <p>24D. LOCATION (City, town, or county) (State)</p> | | <p>25A. DATE REC'D BY HEALTH DEPT. <i>SEP 20 1965</i></p> <p>25B. NAME OF REGISTRAR <i>Robert E. Farber, MA</i></p> <p>25C. FUNERAL DIRECTOR <i>Paul E. ...</i></p> <p>ADDRESS</p> | | | |

Mr. K. L. ...

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44-05-15
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 9586 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9586 | |
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| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Caroline E. Wheeler | | | | 2. DATE AND HOUR OF DEATH September 15, 1965 8:05 P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 13-06 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3440 Hickory Avenue 21211 | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 1-1-1879 | 9. AGE (In years last birthday) 86 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE | | | 10B. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) Maryland | | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | 13. FATHER'S NAME — | | | | |
| 14. MOTHER'S MAIDEN NAME — | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) — | | | | |
| 16. SOCIAL SECURITY NO. — | | | 17. INFORMANT RECORDS: BCH 4940 Eastern Avenue 21224 | | | | |
| 18. 173.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of Ovary ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. — II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. — | | | | CAUSE OF DEATH (A) Carcinoma of Ovary DUE TO (B) — DUE TO (C) — | | INTERVAL BETWEEN ONSET AND DEATH About 1 Year | |
| 19A. DATE OF OPERATION 9-15-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? — | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) — | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) — | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? — | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 3, 1965 to September 15, 1965 , that (I) (we) last saw the deceased alive on September 15, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Dr. Benjamin Hughes | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-15-1965 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Benjamin Hughes | | | | 23D. ADDRESS 4940 Eastern Avenue Balto., Md. 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-18-65 | | 24C. NAME of CEMETERY or CREMATORY ST. MARY'S REM | | 24D. LOCATION (City, town, or county) (State) BALTO. M.D. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | 25B. NAME OF REGISTRAR Paul E. Sharoveth | | 25C. FUNERAL DIRECTOR Paul E. Sharoveth | | | |

1-1-1978

HOUSEWIFE

BURIAL 1-16-78 ST. MARK'S CEM. DACTO. MD.

Paul E. Bennett

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9587 | |
| BIRTH NO. 65 9587 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) CATHERINE VIRGINIA STONE | | SEPTEMBER 14, 1965 4:55P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL | | A. STATE MARYLAND B. COUNTY | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) ARNOLD | |
| | | D. STREET ADDRESS (If rural, give location) 811 BUENA VISTA AVENUE | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 7-9-13 |
| | | 9. AGE (In years last birthday) 52 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY at home | 11. BIRTHPLACE (State or foreign country) MARYLAND |
| 12. CITIZEN OF WHAT COUNTRY? UNITED STATES | | 13. FATHER'S NAME JOHN Earhardt | |
| 14. MOTHER'S MAIDEN NAME SMITH, Anna | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ST. AGNES RECORDS WILKINS AND CATON | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Metastatic Carcinoma DUE TO (B) Carcinoma of Pancreas DUE TO (C) | |
| INTERVAL BETWEEN ONSET AND DEATH unknown | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION January 65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma head of pancreas | |
| 20A. AUTOPSY? (Yes or No) no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from AUGUST 22 1965 to SEPTEMBER 14 1965, that (X) (we) lost saw the deceased alive on SEPTEMBER 14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (X) (I) (We) (did) (X) (X) (not) view the body after death. | | | |
| 23A. SIGNATURE Thomas C. Cimonetti M.D. | | 23B. DATE SIGNED September 14, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) THOMAS C CIMONETTI | | 23D. ADDRESS M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-17-65 | |
| 24C. NAME OF CEMETERY OR CREMATORY Woodland Mem. | | 24D. LOCATION (City, town, or county) (State) Baltimore Co. Md | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR Robert E. Taylor, M.D. | | 25D. ADDRESS Levonia Ph. Inc. | |

UNITED STATES DEPARTMENT OF JUSTICE

INVESTIGATION

REPORT OF

NAME

ADDRESS

DATE

TIME

REPORT OF

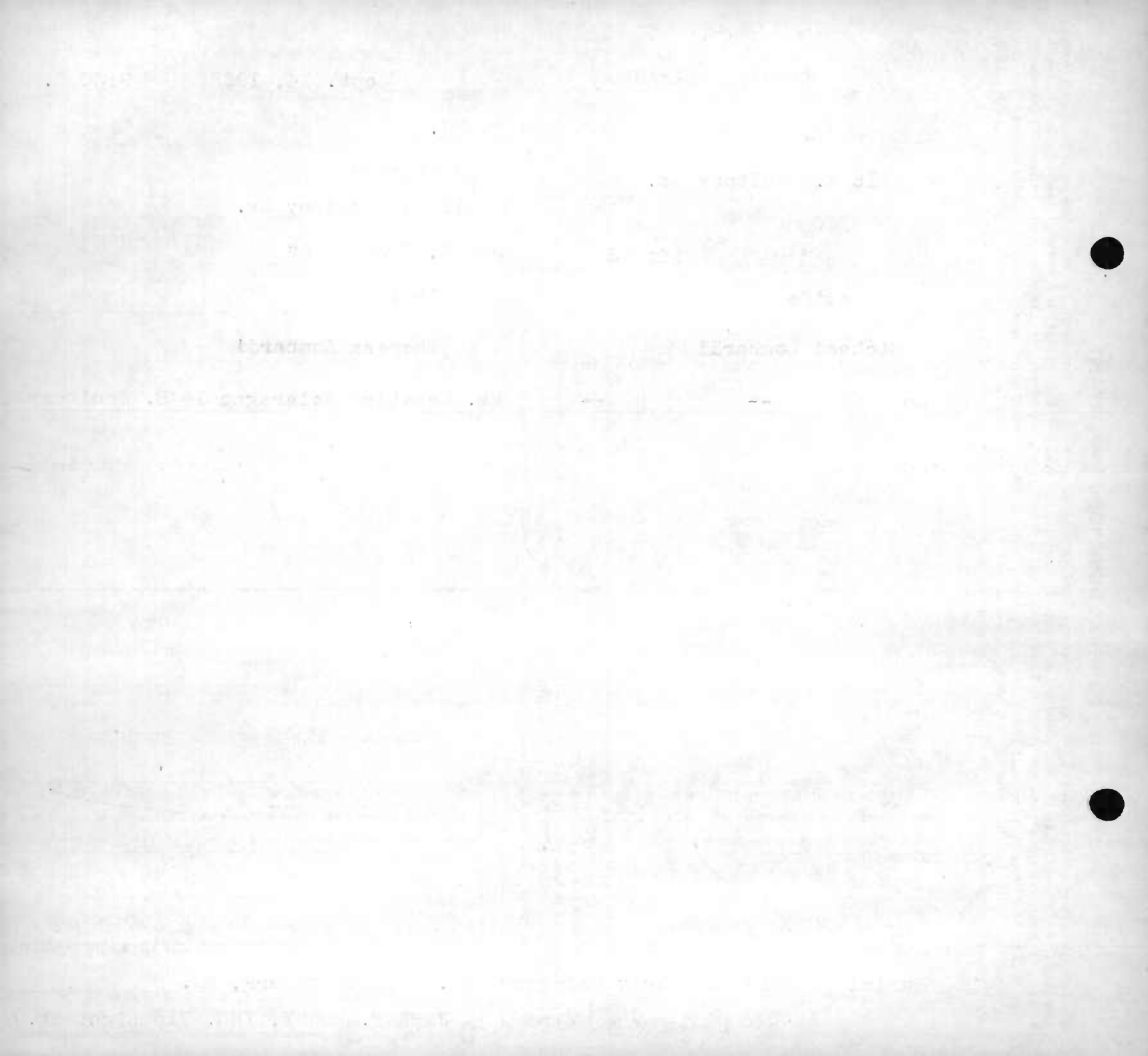
UNITED STATES DEPARTMENT OF JUSTICE

UNITED STATES DEPARTMENT OF JUSTICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9588 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9588 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) MARIA MELARAGNO | | | 2. DATE AND HOUR OF DEATH Sept. 14, 1965 9:30 P. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 16 E. Poultney St. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. 8. COUNTY 23-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 16 E. Poultney St. | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH May 5, '83 | 9. AGE (In years lost birthday) 82 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Italy | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME Michael Lombardi | | | 14. MOTHER'S MAIDEN NAME Theresa Lombardi | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No -- | | 16. SOCIAL SECURITY NO. -- | 17. INFORMANT ADDRESS Mr. Sabatino Melaragno 16 E. Poultney | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH (A) Myocardial infarction DUE TO (B) Coronary Heart Disease DUE TO (C) Arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 19 65 to Sept 14 19 65, that (I) (we) last saw the deceased alive on Sept 12 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Ricardo Lynda | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | 23B. DATE SIGNED 9/16/65 | |
| 23C. PHYSICIAN'S NAME (Type) RICARDO LOZADA | | | 23D. ADDRESS M.D. 1228 S. Charles St. Bal. Md 21230 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9/18/65 | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem. | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | 25B. NAME OF REGISTRAR Robert E. Fadden | 25C. FUNERAL DIRECTOR ADDRESS JOHN F. DENNY, INC. 715 Light St. | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
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| BIRTH NO. 65 9589 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 9589 | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Dorothy Smith</i> | | | | | 2. DATE AND HOUR OF DEATH <i>9/16/65</i> <i>3:51 P</i> M. | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Union Memorial Hosp.</i> | | | | | A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) <i>2327 W. Charles St.</i> | | | | | | | | | |
| 5. SEX <i>♀</i> | | 6. RACE <i>White</i> | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>never married</i> | | 8. DATE OF BIRTH <i>12/20/17</i> | | 9. AGE (In years last birthday) <i>48</i> | | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country) | | | | |
| | | | | | | | | | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | |
| 13. FATHER'S NAME <i>George R. Smith</i> | | | | | | | | | | 14. MOTHER'S MAIDEN NAME <i>Ella Suit</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | | | | 17. INFORMANT ADDRESS | | | | |
| | | | | | | | | | | | | | | |
| 18. <i>434.41</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Cadio-respiratory collapse</i> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | (A) DUE TO | | | | |
| | | | | | | | | | | (B) DUE TO | | | | |
| | | | | | | | | | | (C) DUE TO | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Cerebral palsy</i> | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) <i>No</i> | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) <i>(this hospital)</i> attended the deceased from <i>9/12/65</i> 19 to <i>9/16/65</i> 19, that (I) <i>(we)</i> last saw the deceased alive on <i>9/16/65</i> 19 and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(We)</i> <i>(did)</i> (did not) view the body after death. | | | | | | | | | | | | | | |
| 23A. SIGNATURE <i>Walter D. Boone</i> | | | | | | | | | | 23B. DATE SIGNED <i>9/16/65</i> | | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>WALTER O. BOONE</i> | | | | | | | | | | 23D. ADDRESS <i>Union Memorial Hospital</i> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | | | | 24B. DATE <i>9-20-65</i> | | | | | 24C. NAME OF CEMETERY or CREMATORY <i>Wards Chapel Cemetery</i> | | | | |
| | | | | | | | | | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 20 1965</i> | | | | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | | | | 25C. FUNERAL DIRECTOR <i>Walter Dabrowski</i> | | | | |
| | | | | | | | | | | ADDRESS <i>1005 Dundalk Ave.</i> | | | | |

150000

150000

65 9590

BALTIMORE CITY HEALTH DEPARTMENT

65 9590

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ADOLPH SIPPO

2. DATE AND HOUR PRONOUNCED DEAD

9/15/65 10:07 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5309 Eastern Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

4-4-1907

9. AGE (in years
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Sheet Metal Worker

10B. KIND OF BUSINESS OR INDUSTRY

Eastern Cold Storage Co

11. BIRTHPLACE (State or foreign country)

Finland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown; If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

125-16-4227

17. INFORMANT

ADDRESS

Dorothy Sypp 5309 Eastern Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
m. WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/16/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-18-65

23C. NAME of CEMETERY or CREMATORY

Oakland Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore Md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 20 1965

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Walter Taborski 1005 Dundalk av.

ADDRESS

VALLEY FORD

VALLEY FORD

VALLEY FORD

VALLEY FORD

VALLEY FORD

VALLEY FORD

B 636 9591

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 9591

BIRTH NO.


M.E. CASE NO.

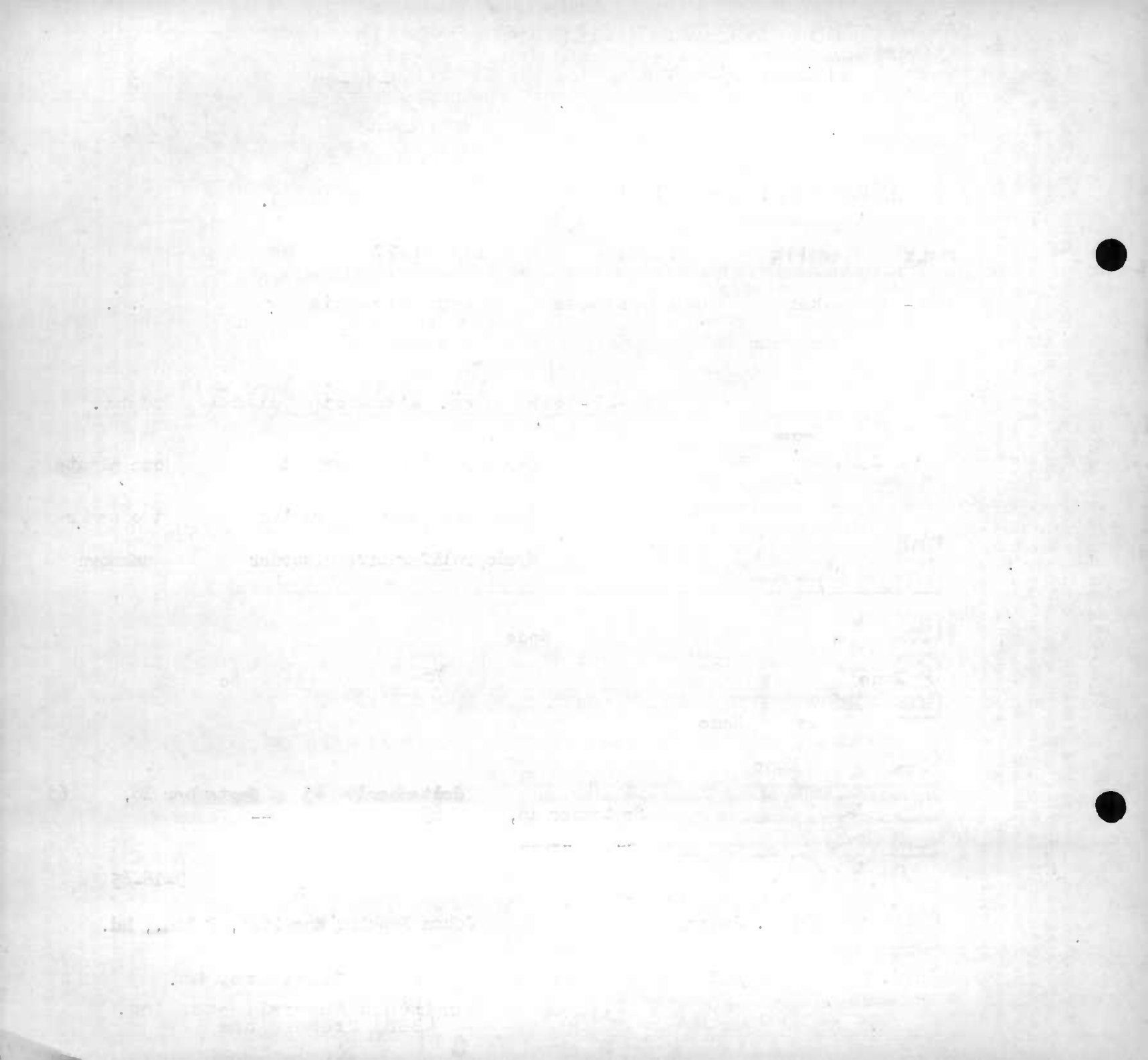
| | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print) Patrick FREDERICK BRUDER | | 2. DATE AND HOUR PRONOUNCED DEAD September 17, 1965 10:45 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 723 N. Streeper St. | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH 2/8/1881 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Produce | | 10B. KIND OF BUSINESS OR INDUSTRY Own Business | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. |
| 13. FATHER'S NAME Frank Bruder | | 14. MOTHER'S MAIDEN NAME Mary Wagner | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 217-32-9140 | 17. INFORMANT Mildred Chaney Bruder, wife, above |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) No |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breitenecker, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 9/21/65 | 23C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery |
| 24A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | 24B. NAME OF REGISTRAR Robert E. Farber | 24C. FUNERAL DIRECTOR Schlimmer Funeral Home, Inc. 2601 E. Madison St. |
| 23D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | |

MAILED FORGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

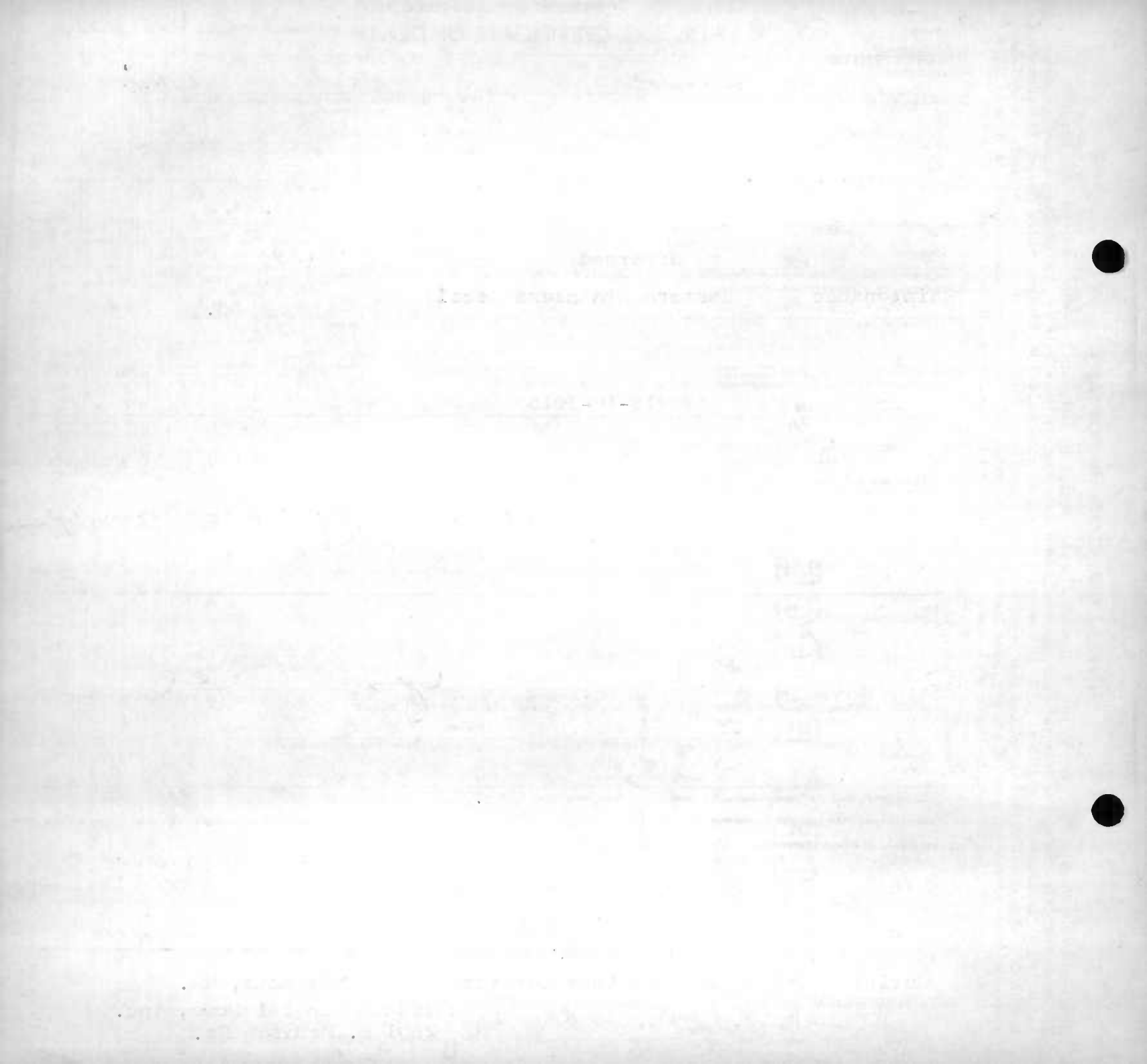
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|---------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| S 252 65 9592 | | CERTIFICATE OF DEATH | | 65 9592 | |
| BIRTH NO. | | M.E. CASE NO. | | A | |
| 1. NAME OF DECEASED (Type or Print) VINCENT SUCHANEK | | 2. DATE AND HOUR OF DEATH 9-16-65 | | M. 3 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL | | A. STATE MARYLAND B. COUNTY 9-06 | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) 2926 HARFORD RD. | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWER | 8. DATE OF BIRTH 11/8/1877 | 9. AGE (In years lost birthday) 87 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret-Shoemaker | | 10B. KIND OF BUSINESS OR INDUSTRY own business | | 11. BIRTHPLACE (State or foreign country) Czechoslovakia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME unknown | | 14. MOTHER'S MAIDEN NAME unknown | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 218-22-0685 | | 17. INFORMANT ADDRESS 1514 Northgate Road - 18 Mrs. Elizabeth Tulacek dght. | |
| 18. 299X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Cardiorespiratory arrest DUE TO (B) Blood loss and dehydration DUE TO (C) Myeloproliferative disorder | | INTERVAL BETWEEN ONSET AND DEATH one minute two weeks unknown | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None | | | | | |
| 19A. DATE OF OPERATION 2 None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) None | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) None | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from September 15, 1965 to September 16, 1965 , that (I) (we) last saw the deceased alive on September 16, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE  | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-16-65 | |
| 23C. PHYSICIAN'S NAME (Type) Jay B. Jensen | | 23D. ADDRESS Johns Hopkins Hospital, Balto., Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9/20/65 | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | 25B. NAME OF REGISTRAR Robert E. Jasky | | 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9593 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9593 | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|------------------------------------------------------------------------------------|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>JAMES VAIN</u> | | | | 2. DATE AND HOUR OF DEATH <u>September 16, 1965-8:10 A.M.</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>18 MARYLAND GEN. HOSPITAL</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>6-01</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>427 N. LINWOOD</u> | | | |
| 5. SEX <u>M</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>divorced</u> | 8. DATE OF BIRTH <u>4/12/06</u> | 9. AGE (In years last birthday) <u>59</u> | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Eastern Stainless Steel</u> | | 11. BIRTHPLACE (State or foreign country) <u>BALTIMORE Md.</u> | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | 13. FATHER'S NAME <u>?</u> | | | | |
| 14. MOTHER'S MAIDEN NAME <u>ANNA</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | | | |
| 16. SOCIAL SECURITY NO. <u>215-10-1016</u> | | | 17. INFORMANT <u>MILOROS JONES</u> ADDRESS <u>5617 PINEVIEW DRIVE</u> | | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Wrenia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Chronic Glomerulonephritis</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 14</u> 19 <u>65</u> to <u>Sept. 16</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Sept. 16</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Helen Ann Sabundago</u> M.D. | | | | 23B. DATE SIGNED <u>Sept. 16, 1965</u> | | 23C. PHYSICIAN'S NAME (Type) <u>ROLEND M SABUNDAGO</u> M.D. | |
| 23D. ADDRESS <u>Manyland Gen. Hospital</u> | | | | 23E. MED. DIRECTOR <input type="checkbox"/> | | 23F. STAFF PHYS. <input checked="" type="checkbox"/> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9/20/65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Oak Lawn Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 20 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Farley</u> | | 25C. FUNERAL DIRECTOR <u>Schlimmer Funeral Home, Inc.</u> | | 25D. ADDRESS <u>2601 E. Madison St.</u> | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 22618 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9594 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------|-------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-----------------------------------------------------------------------------|------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Butler, Baby Boy, Sharon (John L. Webb, Jr.) | | | | 2. DATE AND HOUR OF DEATH 9/14/65 7:10 A. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland, #21224 | | | | A. STATE Maryland | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 2230 Booth Street, #21223 | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Newborn | 8. DATE OF BIRTH 9-12-65 | 9. AGE (In years last birthday) 2 | If Under 1 Yr. Months | If Under 24 Hrs. Days | If Under 24 Hrs. Hours |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME John L. Webb | | | | 14. MOTHER'S MAIDEN NAME Sharon Butler | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS RECORDS: BCH, 4940 Eastern Ave., #21224 | | |
| 18. 75-9.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Gastroschisis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | | |
| 19. DATE OF OPERATION 3 9/12/65 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Gastroschisis | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-12-65 19 to 9-14- 19 65, that (I) (We) last saw the deceased alive on 9-14- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE S. Wayne Klein | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> 1 | | 23B. DATE SIGNED 9/14/65 | |
| 23C. PHYSICIAN'S NAME (Type) DR. S. WAYNE KLEIN | | | | 23D. ADDRESS M.D. 4940 Eastern Ave., Balto., Md., #21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-16-65 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Charles R. Law, 802 Madison Ave. | | | |

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John L. Webb, Jr., Secretary

John L. Webb, Jr., Secretary

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John L. Webb, Jr., Secretary

John L. Webb, Jr., Secretary

John L. Webb, Jr., Secretary

John L. Webb, Jr., Secretary

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John L. Webb, Jr., Secretary

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John L. Webb, Jr., Secretary

John L. Webb, Jr., Secretary

John L. Webb, Jr., Secretary

John L. Webb, Jr., Secretary

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John L. Webb, Jr., Secretary

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>65 9595</u> | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------|
| BIRTH NO. <u>65 9595</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Mrs. Elizabeth T. Schmitt</u> | | 2. DATE AND HOUR OF DEATH <u>Sept. 16, 1965</u> <u>5:00 A.</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>2649 Maryland Ave</u> | | A. STATE <u>Maryland</u> B. COUNTY <u>12-06</u> | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>2649 Maryland Ave</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>May 30,</u> | 9. AGE (In years last birthday) <u>86</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME <u>Joseph A. Tewes</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Dorothea M. Zeilmann</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>Miss C.P. Tewes 2649 Maryland Ave</u> | | | |
| 18. <u>422.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | CAUSE OF DEATH (A) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO (B) <u>Severe rheumatoid arthritis</u> DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u> <u>20 yrs.</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>January</u> 19 <u>53</u> to <u>Sept. 16,</u> 19 <u>65</u> , that (I) (we) lost saw the deceased alive on <u>September 13, 19 65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Lloyd E. Saylor</u> M.D. | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>Sept. 16, 1965</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Lloyd E. Saylor</u> | | 23D. ADDRESS <u>3902 Greenmount Avenue</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9/18/65</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 20 1965</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Howe Means & Son 805 N. Calvert St.</u> | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-----------------------------------------------------------------------------------------------------------|------------------------------------------|
| BIRTH NO. 65 9596 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9596 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Pirock, George Michael, Sr.</i> | | 2. DATE AND HOUR OF DEATH <i>9/16/65 8:43 A.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | 5. STATE <i>Maryland</i> 6. COUNTY <i>Baltimore</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>The Union Memorial Hospital</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Essex (21) Middleborough</i> | | D. STREET ADDRESS (If rural, give location) <i>1902 Middleborough Road</i> | |
| 5. SEX <i>male</i> | 6. RACE <i>white</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <i>Married</i> | 8. DATE OF BIRTH <i>5-7-20</i> | 9. AGE (In years lost birthday) <i>45</i> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Slitter</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Can Company</i> | | 11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>American</i> | | 13. FATHER'S NAME <i>John Pirock</i> | | 14. MOTHER'S MAIDEN NAME <i>Susan</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WWII</i> | | 16. SOCIAL SECURITY NO. <i>199-01-8780</i> | | 17. INFORMANT <i>Mrs. Rosemary Pirock</i> | |
| 18. <i>202.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>lymphoma</i> | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION <i>9-14-65</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Exploratory Laparotomy</i> | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i> | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (this hospital) attended the deceased from <i>9-8-65</i> to <i>9-16-65</i> , that (we) last saw the deceased alive on <i>9-16-65</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (view) the body after death. | | | |
| 23A. SIGNATURE <i>A. C. Tipton Jr.</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>9/16/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>A. C. TIPTON JR.</i> | | M.D. 23D. ADDRESS <i>The Union Memorial Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>9/20/65</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart of Jesus Cemetery, Baltimore Co., Maryland</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore Co., Maryland</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 20 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Farkas</i> | |
| 25C. FUNERAL DIRECTOR <i>Bruzdinski Funeral Home</i> | | 25D. ADDRESS <i>1407 Eastern Ave.</i> | | | |

TEST 9

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

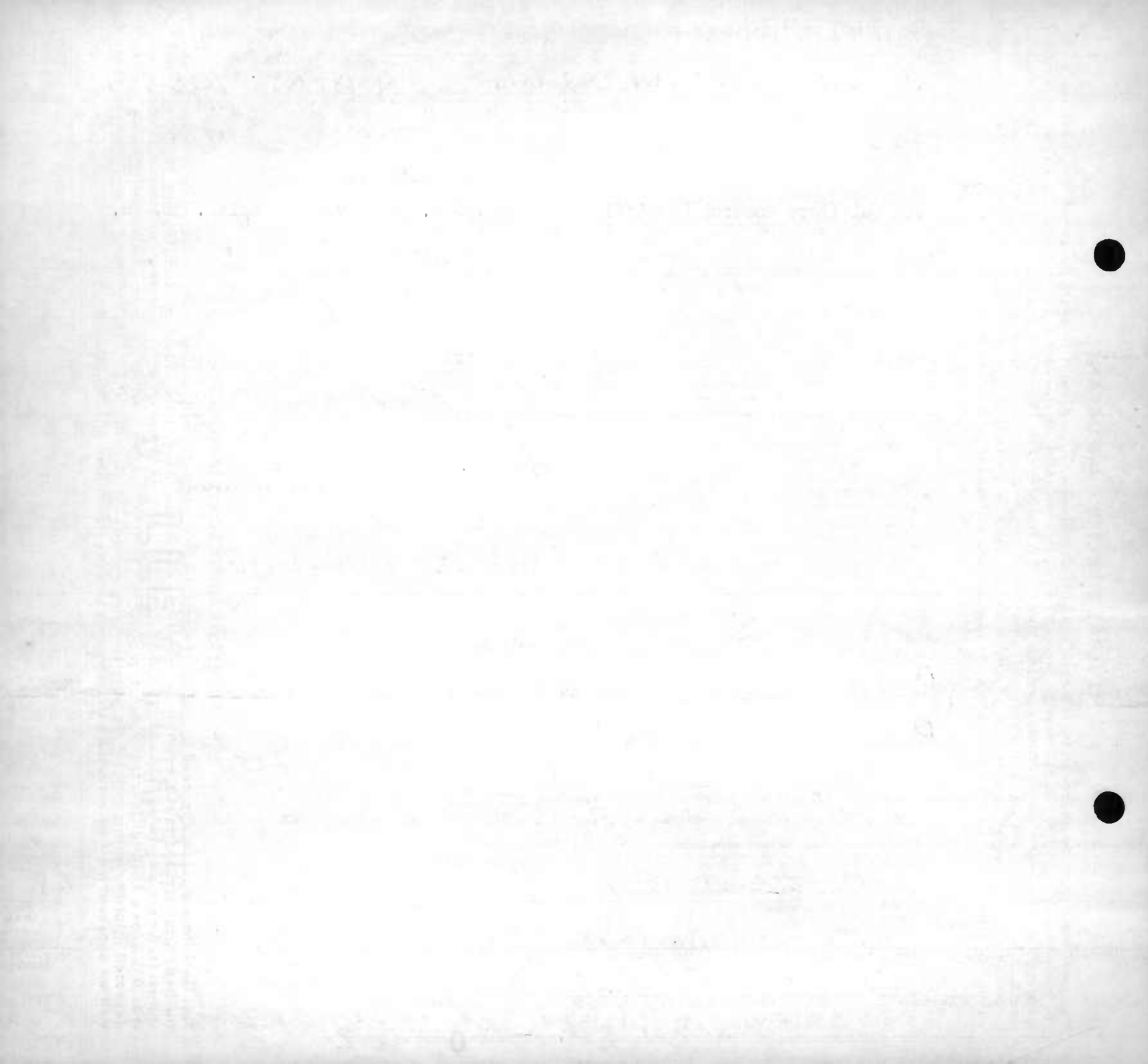
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| BIRTH NO. 65 22942 | | Baltimore City Health Department | | Registered No. 65 9597 | |
| M.E. CASE NO. 65 9597 | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) Baby Boy Stacy | | | 2. DATE AND HOUR OF DEATH 9-15-65 950 A M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hosp | | | A. STATE Maryland B. COUNTY Howard | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Ellicott City 6300 | | |
| | | | D. STREET ADDRESS (If rural, give location) 109 main st. | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH 9-14-65 | 9. AGE (In years lost birthday) | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 5 6 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| | | | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13. FATHER'S NAME James Stacy | | | 14. MOTHER'S MAIDEN NAME Mary Shelton | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT Chart ADDRESS | |
| 18. 762.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | |
| ANTECEDENT CAUSES | | | (A) DUE TO Pulmonary atelectasis | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO Immaturity | | |
| | | | (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-14 19 65 to 9-15 19 65 that (I) (we) last saw the deceased alive on 9-15 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Charlie H Francis M.D. | | | | 23B. DATE SIGNED 9-15-65 | |
| 23C. PHYSICIAN'S NAME (Type) University Hosp. | | | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-16-65 | | 24C. NAME OF CEMETERY or CREMATORY Good Shepherd | |
| | | | | 24D. LOCATION (City, town, or county) Ellicott City Md. (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR F. C. Higginbotham | |
| | | | | ADDRESS Ellicott City Md. | |

1727-1728

FUNERAL DIRECTOR: IMPORTANT

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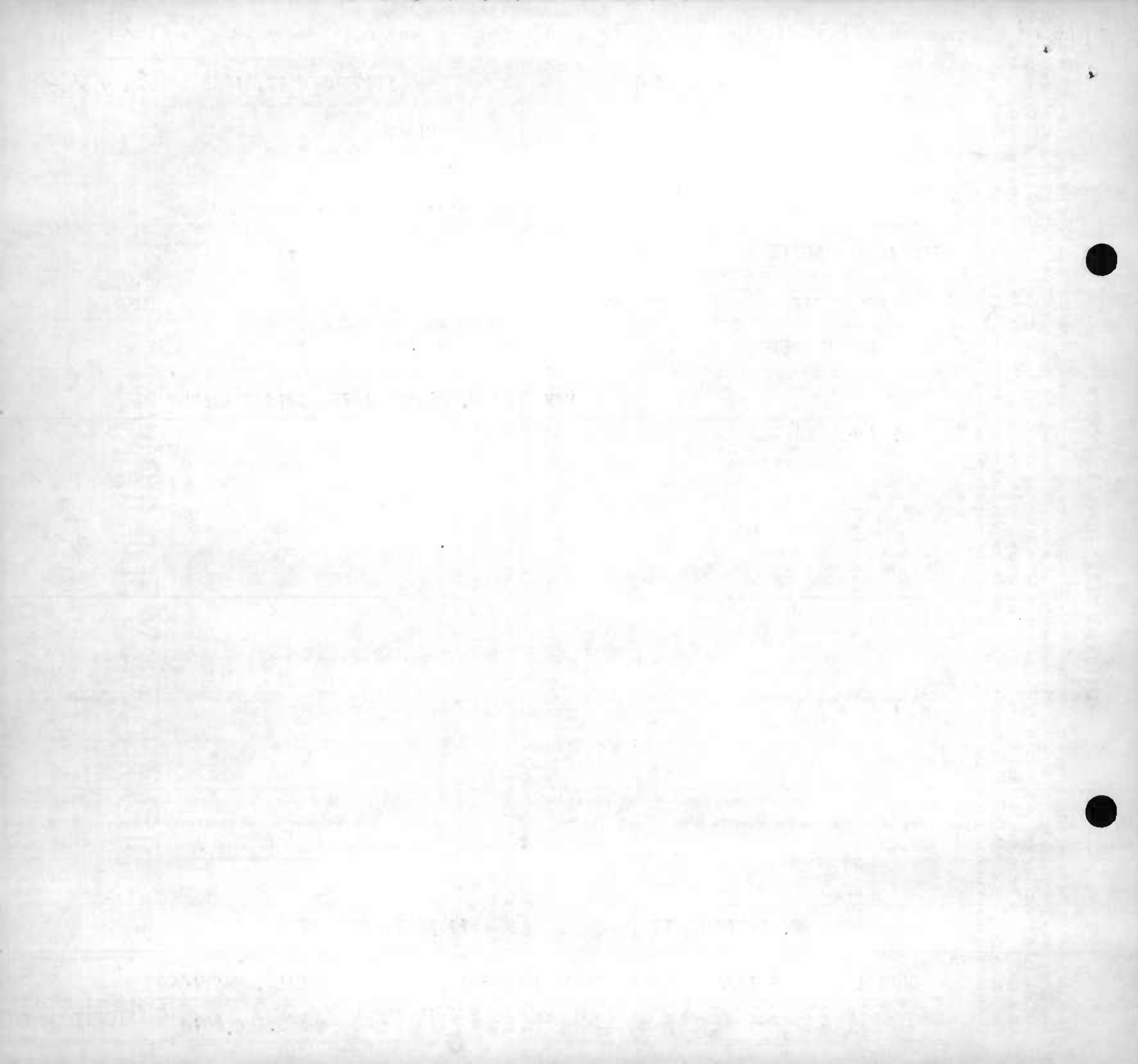
| BIRTH NO. 65 9598 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9598 | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) NELLIE CINQUEGRANI | | | | 2. DATE AND HOUR OF DEATH 9-18-65 10:54 AM M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY 2402 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hospital (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 706 E. Fort Avenue Balto. 30, Md. | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 12/3/1885 | 9. AGE (In years last birthday) 79 | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | 11. BIRTHPLACE (State or foreign country) Italy | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME Joseph | | | 14. MOTHER'S MAIDEN NAME Marie | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Family ADDRESS Same | | |
| 18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION ANTECEDENT CAUSES (B) ASCVD DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (C) DIABETES MELLITUS | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that on (this hospital) attended the deceased from 9/17 19 65 to 9/18/1 19 65 , that on (we) lost saw the deceased alive on 9-18 19 65 and that in our (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Dr. Matthew J. Kaufmann M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-18-65 | |
| 23C. PHYSICIAN'S NAME (Type) DR. MATTHEW KAUFMANN M.D. | | | | 23D. ADDRESS South Balto. Gen. Hospital - 1313 Light St. Balto. Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) B | | 24B. DATE 9-21-65 | | 24C. NAME of CEMETERY or CREMATORY Holy Redeemer | | 24D. LOCATION (City, town, or county) (State) Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | 25B. NAME OF REGISTRAR Robert E. Finkema | | 25C. FUNERAL DIRECTOR McCully - 130 E. Towles | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

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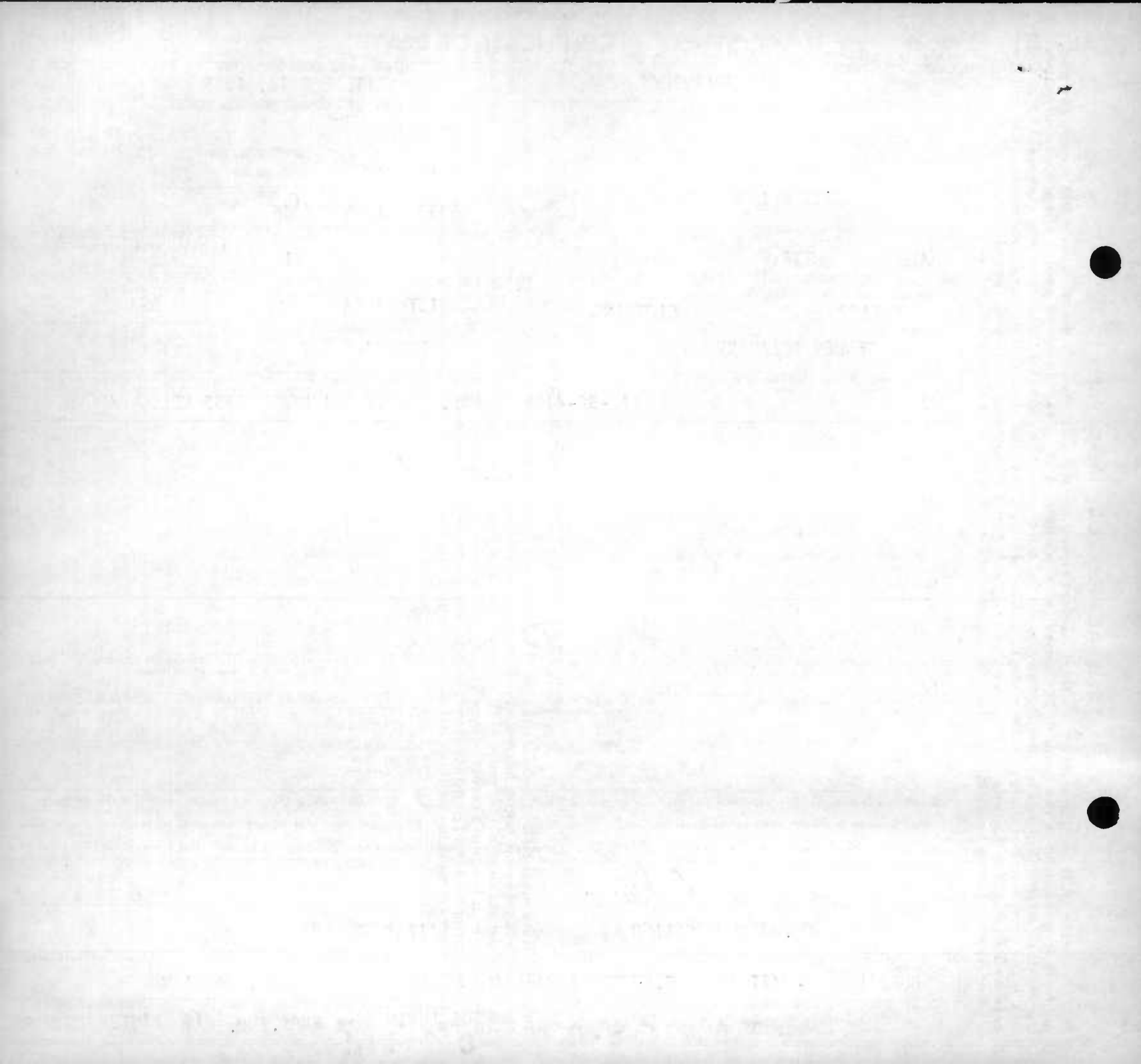
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------|--|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--|----------------------------------------------|--|--------------------------------------------------------------------------|--|-----------------------------|--|--|
| BIRTH NO. 65 9599 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 9599 | | | | |
| 1. NAME OF DECEASED (Type or Print) JENNIE ARENOV | | | | | 2. DATE AND HOUR OF DEATH SEPTEMBER 17, 1965 12:47 A.M. | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MARYLAND B. COUNTY 27-17 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 5111 PEMBRIDGE AVENUE | | | | | | | | | |
| 5. SEX FEMALE | | 6. RACE WHITE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | | 8. DATE OF BIRTH | | 9. AGE (In years lost birthday) 70 | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | | | | | 11. BIRTHPLACE (State or foreign country) RUSSIA | | | | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | 13. FATHER'S NAME HENRY SHERR | | | | | 14. MOTHER'S MAIDEN NAME MARY ? | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | | 16. SOCIAL SECURITY NO. XXX | | | | | 17. INFORMANT MR. HARRY KLAFF | | | | |
| | | | | | ADDRESS 3413 TERRAPIN ROAD | | | | | | | | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarct CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH ? | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) | | | | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from October 19 62 to June 19 65 , that (I) (we) last saw the deceased alive on June 20, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 23A. SIGNATURE Irvin Hyatt M.D. Attending Phys. <input checked="" type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | | | | | | | 23B. DATE SIGNED 9/18/65 | | | | |
| 23C. PHYSICIAN'S NAME (Type) DR. IRVIN HYATT | | | | | | | | | | 23D. ADDRESS 11 EAST CHASE STREET M.D. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | | | 24B. DATE 9/19/65 | | | | | 24C. NAME of CEMETERY or CREMATORY BETH JACOB (VECAIR) | | | | |
| 24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND | | | | | | | | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | | | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | | | | 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. 6010 | | | | |
| | | | | | | | | | | ADDRESS REISTERSTOWN RD | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>65 9600</u> | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------|------------------------------------------|
| BIRTH NO. <u>65 9600</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. <u>65 9600</u> | | 1. NAME OF DECEASED (Type or Print) <u>MAX POLANSKY</u> | | 2. DATE AND HOUR OF DEATH <u>SEPTEMBER 16, 1965</u> <u>8 A</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>5333 NELSON AVENUE</u> | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>27-18</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>5333 NELSON AVENUE</u> | | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH | 9. AGE (In years last birthday) <u>71</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAILOR</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>CLOTHING</u> | | 11. BIRTHPLACE (State or foreign country) <u>LITHUANIA</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>REUBEN POLANSKY</u> | | 14. MOTHER'S MAIDEN NAME <u>REBECCA ?</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>212-32-4499</u> | | 17. INFORMANT ADDRESS <u>MRS. FANNIE POLANSKY 5333 NELSON AVENUE</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>420.1 d 250X</u> <u>Coronary Sci</u> <u>ASCVD</u> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | (B) DUE TO | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <u>Diabetes</u> | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>7-1-1955</u> to <u>9-16-1965</u> , that (I) (we) last saw the deceased alive on <u>9-16-1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Jerome Coller</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>9-16-65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>DR. JEROME COLLER</u> | | 23D. ADDRESS <u>2217 SOUTH ROAD</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>9/17/65</u> | | 24C. NAME of CEMETERY or CREMATORY <u>TIFERETH ISRAEL ANSHE SFARD</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>ROSEDALE, MARYLAND</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 20 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Talbot</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9601 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 65 9601 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MRS. BELLE LEVIN | | 2. DATE AND HOUR OF DEATH SEPTEMBER 16, 1965 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) PALL MALL NURSING HOME 4601 PALL MALL ROAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 27-17 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3004 OAKLEY AVENUE | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 3/25/1896 | 9. AGE (In years lost birthday) 69 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (State or foreign country) POLAND | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME SHEAH JOSEPH NEWMARK | | | |
| 14. MOTHER'S MAIDEN NAME BAILA ? | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | |
| 16. SOCIAL SECURITY NO. C | | 17. INFORMANT MRS. HANNAH GOLDFINGER ADDRESS 3023 W GARRISON AVE | | | |
| 18. 153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of Colon ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. none | | CAUSE OF DEATH (A) Carcinoma of Colon DUE TO (B) none DUE TO (C) none | | INTERVAL BETWEEN ONSET AND DEATH 3 months | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. none | | | | | |
| 19A. DATE OF OPERATION 08/1/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA 9 colon | | 20A. AUTOPSY? (Yes or No) no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from August 1 19 65 to Sept 16 19 65 , that (I) (we) last saw the deceased alive on Sept 16 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Manuel Levin | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9/10/65 | |
| 23C. PHYSICIAN'S NAME (Type) MANUEL LEVIN | | 23D. ADDRESS 4818 Reisterstown Rd | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/17/65 | | 24C. NAME of CEMETERY or CREMATORY WORKMENS CIRCLE | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Fairbank | | 25C. FUNERAL DIRECTOR 6000 Reisterstown Rd | | | |

21

Channing & Lister
in London & New York

from
London
New York

after the 1st of June

June 1st 1872

MANUEL LEON
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MANUEL LEON

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| 60-13916 65 9602 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9602 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | 2. DATE AND HOUR OF DEATH | |
| M.E. CASE NO. | | | | 9-16-65 10:10 A.M. | |
| 1. NAME OF DECEASED (Type or Print) | | MICHAEL GARY WIENER | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | SINAI HOSPITAL | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | |
| MALE | | WHITE | | NEVER MARRIED | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH | |
| NONE | | NONE | | 5-20-60 | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 9. AGE (In years last birthday) | |
| Herbert Wiener | | SMITH, BESSIE | | 5 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| NO | | NONE | | Father | |
| 18. 193.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CNS Tumor | | 3 1/2 yrs. | |
| ANTECEDENT CAUSES | | (A) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| O | | | | NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (He/She/It) (this hospital) attended the deceased from 9-3-1965 to 9-16-1965, that (He/We) last saw the deceased alive on 9-16-1965 and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (He/We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| E.C. CRUZ | | | | 9-16-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| | | Sinai Hospital, Baltimore | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| BURIAL | | 9/17/65 | | Ohr Kneseth Israel Anshe Sfard | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| SEP 20 1965 | | Robert E. Jankowski | | Sol KENISON + Bros Inc. 6010 REISTERSTOWN RD | |

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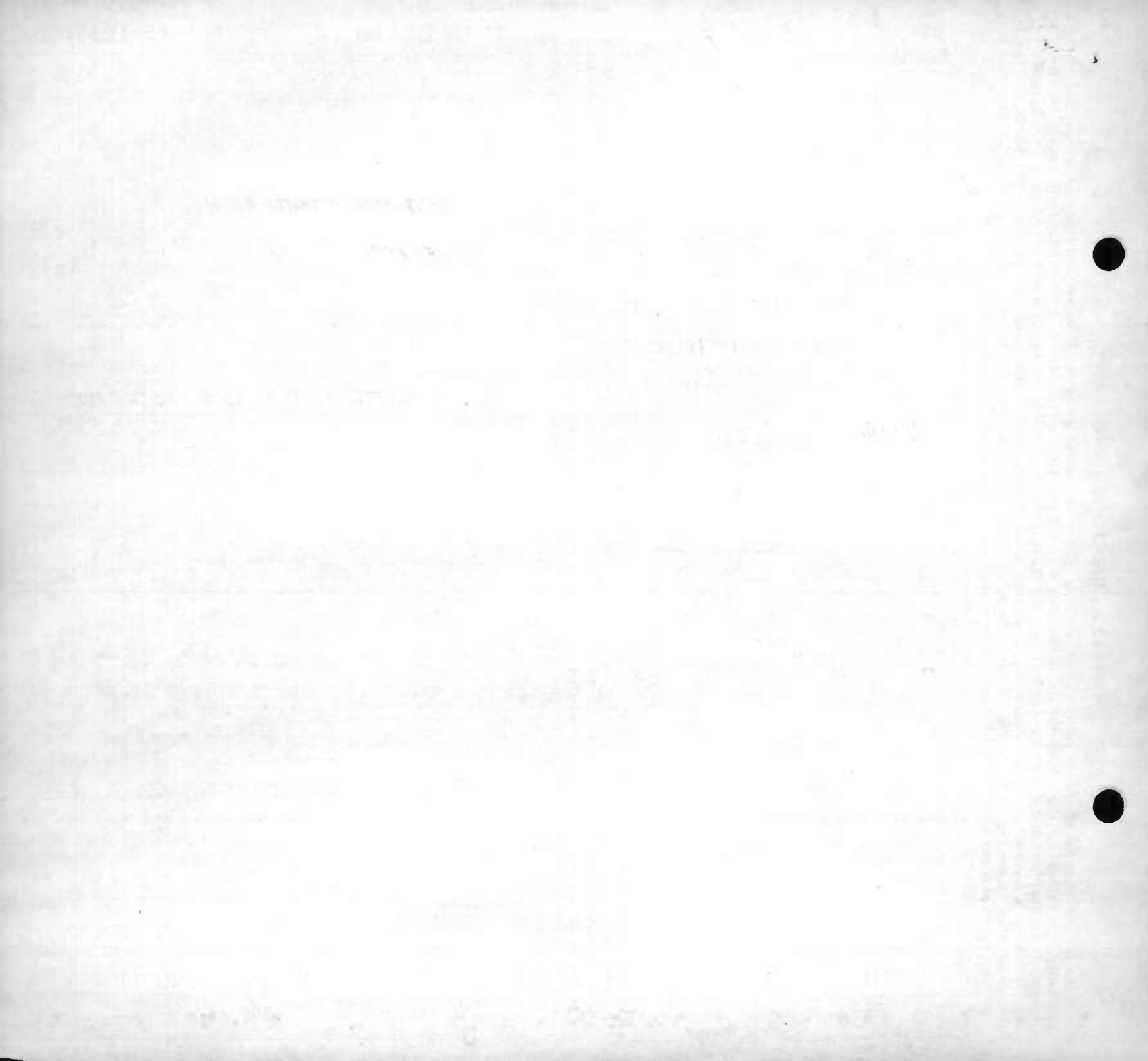
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FUNERAL DIRECTOR: IMPORTANT

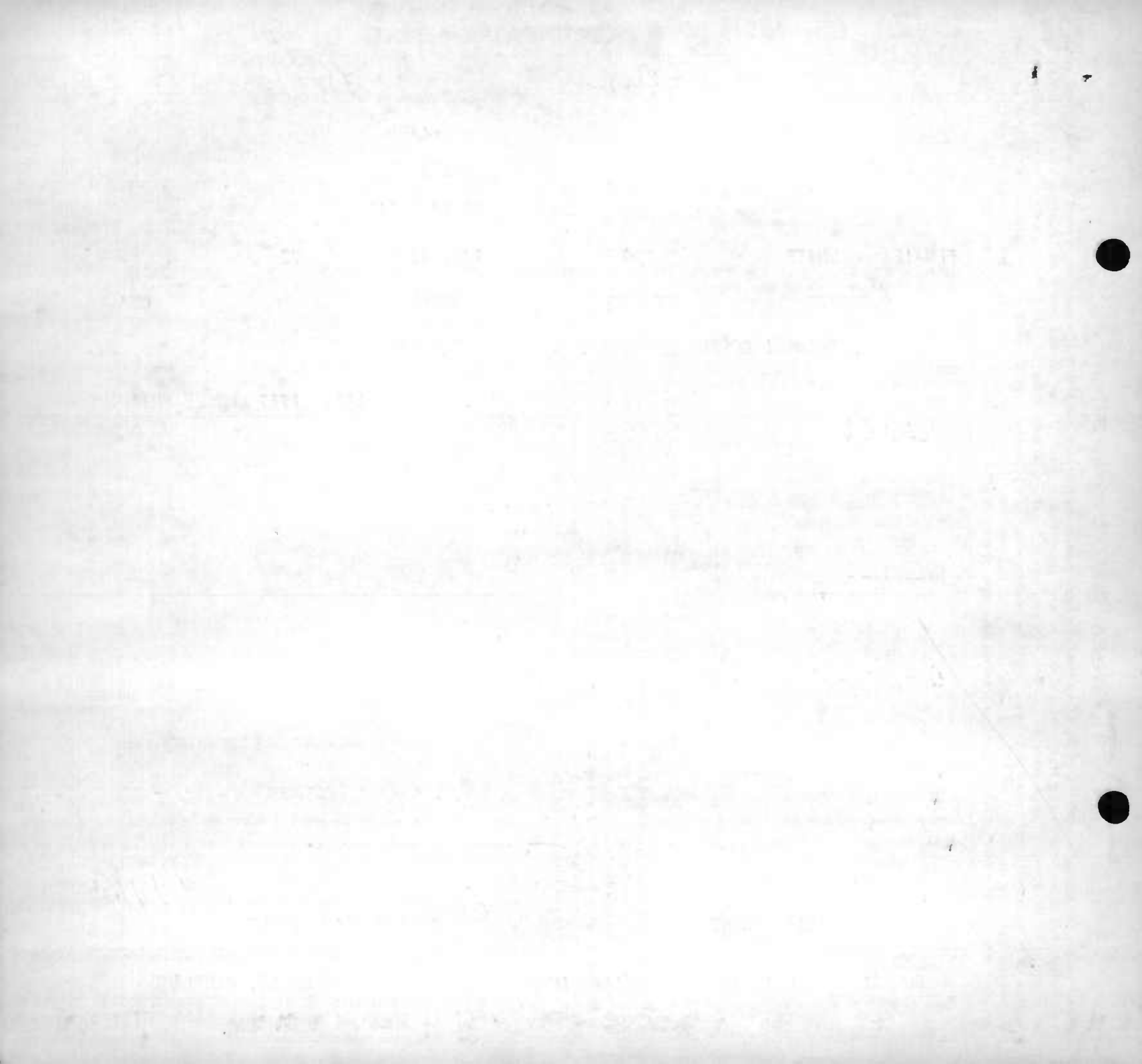
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9603 M.E. CASE NO. 76 4743 1. NAME OF DECEASED (Type or Print) <i>Ko/ker, Fannie</i> | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH Registered No. 65 9603 | | 2. DATE AND HOUR OF DEATH <i>9-16-65</i> <i>4:40 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Singi Hospital Baltimore, Md.</i> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY <i>15-13</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>2657 PARK HEIGHTS TERRACE</i> | | |
| 5. SEX <i>FEMALE</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i> | 8. DATE OF BIRTH <i>8/15/1891</i> | 9. AGE (In years last birthday) <i>74</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i> | | 11. BIRTHPLACE (State or foreign country) <i>Russia</i> | |
| 13. FATHER'S NAME <i>ISRAEL KESSLER (KLECEL)</i> | | | 14. MOTHER'S MAIDEN NAME <i>MARYX ?</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <i>MRS. JEANNETTE KUSHNER 5306 LYNVIEW AVE</i> | |
| 18. <i>4201</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) <i>(Probable) myocardial infarction</i> DUE TO (B) <i>Coronary thrombosis</i> DUE TO (C) <i>Arteriosclerotic cardiovascular disease</i> | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>9/16</i> 19 <i>65</i> to <i>9/16</i> 19 <i>65</i> , that (I) was saw the deceased alive on <i>9-16</i> 19 <i>65</i> and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death. | | | | | |
| 23A. SIGNATURE <i>Leonard J. Hertzberg, M.D.</i> | | | | 23B. DATE SIGNED <i>9-16-65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Leonard J. Hertzberg M.D.</i> | | 23D. ADDRESS <i>Singi Hospital Baltimore, Md.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>9/19/65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>KNESSETH ISRAEL KOLK WOLYN</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>BALTIMORE MARYLAND</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 20 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Fairbank</i> | | 25C. FUNERAL DIRECTOR'S ADDRESS <i>SOL LEVINSON & BROS. INC. 6000 REISTERSTOWN RD</i> | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Decreased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

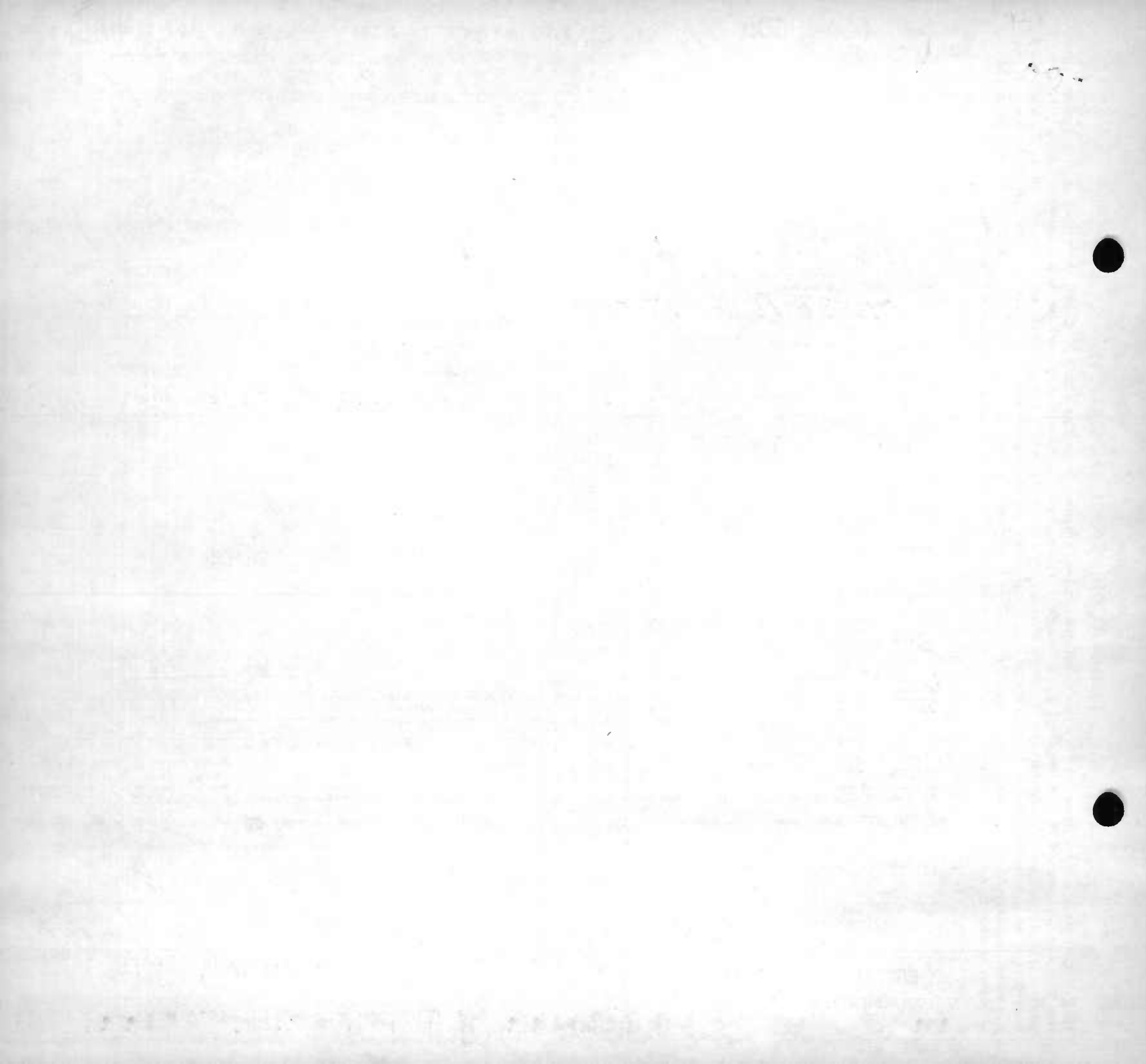
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| BIRTH NO. 65 9604 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9604 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Goldie Ellin</i> | | 2. DATE AND HOUR OF DEATH <i>9/17/65 2:20 A.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>2720</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>6310 WALLIS AVENUE</i> | | (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location) <i>6310 WALLIS AVENUE</i> | |
| 5. SEX <i>FEMALE</i> | 6. RACE <i>WHITE</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>WIDOWED</i> | 8. DATE OF BIRTH <i>1/28/1893</i> | 9. AGE (In years last birthday) <i>72</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i> | | 11. BIRTHPLACE (State or foreign country) <i>RUSSIA</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>NATHANIEL ROSEN</i> | | 14. MOTHER'S MAIDEN NAME <i>DEBORAH ?</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <i>MR. MARVIN ELLIN 1717 MUNSEY BUILDING</i> | |
| 18. <i>202.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Lymphoma</i> | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION <i>04/17/65</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Lymphoma</i> | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>April</i> 19 <i>65</i> to <i>Sept</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>Sept 16</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Allan Macht</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>9/15/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>ALLAN MACHT</i> | | 23D. ADDRESS <i>2 EAST READ STREET</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>9/19/65</i> | | 24C. NAME of CEMETERY or CREMATORY <i>MARYLAND LODGE</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>ROSEDALE, MARYLAND</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 20 1965</i> | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Johnson</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital, and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. 65 9605 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9605 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Wallack, Lena | | | 2. DATE AND HOUR OF DEATH 9-17-65 11:15 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital Baltimore, Md. | | | A. STATE Md. B. COUNTY 15-13 | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | D. STREET ADDRESS (If rural, give location) 2512 Loyola Southway | | |
| 5. SEX FEMALE | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 9-10-1884 | 9. AGE (In years last birthday) 81 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (State or foreign country) Russia | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | 13. FATHER'S NAME Altman | | |
| 14. MOTHER'S MAIDEN NAME GERTRUDE ? | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS MRS. FLORENCE CAUTALE 5925 Wooten Road | | |
| 18. 465 XX+260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) Pulmonary edema DUE TO (B) Congestive Heart Failure DUE TO (C) Probable Pulmonary embolus | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (this hospital) attended the deceased from 9-8 19 65 to 9-17 19 65, that (I) last saw the deceased alive on 9-17 19 65 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE L. J. Hertzberg | | | 23B. DATE SIGNED 9-17-65 | | |
| 23C. PHYSICIAN'S NAME (Type) L. J. Hertzberg | | | 23D. ADDRESS Sinai Hospital Baltimore, Md. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/19/65 | | 24C. NAME of CEMETERY or CREMATORY BETH EL | |
| 24D. LOCATION (City, town, or county) (State) RANDALLSTOWN, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | 25B. NAME OF REGISTRAR SOL LEVINSON & BROS. INC. 6010 REESTERTOWN RD | |
| 25C. FUNERAL DIRECTOR | | 25D. ADDRESS | | | |



| BIRTH NO. 65 9606 | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 9606 | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. | | | | | |
| M-240 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR PRONOUNCED DEAD | | |
| CHARLES MCGILL | | | 9/18/65 2:40 a. M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | A. STATE Maryland B. COUNTY | | |
| Provident Hospital | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | | |
| | | | Baltimore | | |
| D. STREET ADDRESS (If rural, give location) | | | 15-02 | | |
| 1320 N. Mount St. | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| male | colored | Never Married | May 20, 1935 | 30 | |
| 108. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| | | | S.C. | | U.S.A. |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| George McGill | | | Eloise Grahm | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 213 32 8915 | | Eloise McGill 1320 Mount St. | |
| 18. CAUSE OF DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | |
| (A) Retroperitoneal hemorrhage | | | | | |
| DUE TO | | | | | |
| (B) Gunshot wound of abdomen | | | | | |
| (C) | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | street | | near 1601 Laurens St. | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| 9 18 65 1:55 a. | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | shot in abdomen | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | |
| EXAMINER'S NAME (Type) | | | DATE SIGNED | | |
| Werner U. Spitz, M.D. | | | 9/18/65 | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 9/21/65 | | Mt. Auburn Cem. | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR | |
| SEP 20 1965 | | Robert E. Farley, M.D. | | George A. Kelen 1348 N. Calhoun St. | |
| 24D. LOCATION (City, town, or county) | | 24E. ADDRESS | | | |
| Baltimore, Md. | | | | | |

WILLIAM H. ROSE

Never Reported May 20, 1932

S.C. E.S.A.

Richard Graham

George McGill

SL 33 6015 Richard McGill 1350 Mount St.

80

Burial 9/21/62 St. Andrew Cem. Baltimore, Md.

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ALEXANDER KEYS

2. DATE AND HOUR PRONOUNCED DEAD

9/18/65 6:40 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Joseph Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1205 Wilcox St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Jan. 15, 1904

9. AGE (In years
last birthday)

61

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

218-03-4012

17. INFORMANT

ADDRESS

Francis Keys 1205 Wilcox St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/18/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/22/65

23C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 20 1965

Robert E. Taylor

Spitz, M.D. 1348 N. Calhoun St

VALLEY FORCE

Handled

Jan. 15, 1904

Ve.

O.S.A.

215-03-4015 Francis News 1205 Wilson St.

Serial 9/25/02 Mr. Andrew Gann. Baltimore, Maryland

1

65 9608

BALTIMORE CITY HEALTH DEPARTMENT

65 9608

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

SAMUEL LEVIN MACER

2. DATE AND HOUR PRONOUNCED DEAD

September 16, 1965 8:33 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

920 Harlem Avenue

5. SEX

male

6. RACE

negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

Oct 1 - 1902

9. AGE (In years
lost birthday)

63

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Cambridge, Md

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

15. WAS DECEASED EVER IN U.S. ARMS FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Florence Macer Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 17, 1965

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-20-1965

23C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cem

23D. LOCATION

Baltimore

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

SEP 20 1965

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Choy Wilson 1000 Beauty

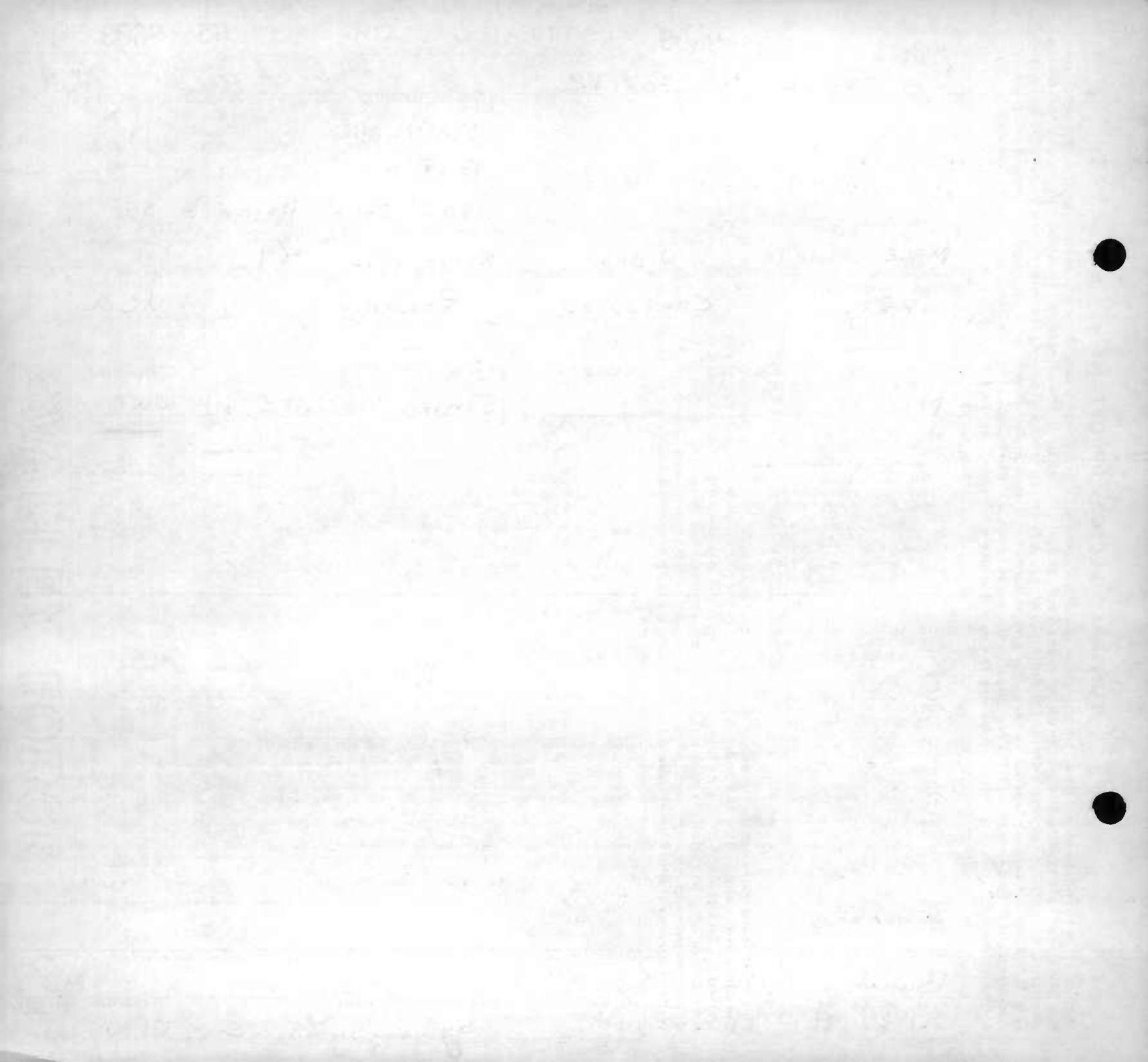
ADDRESS

WATKINS & SONS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

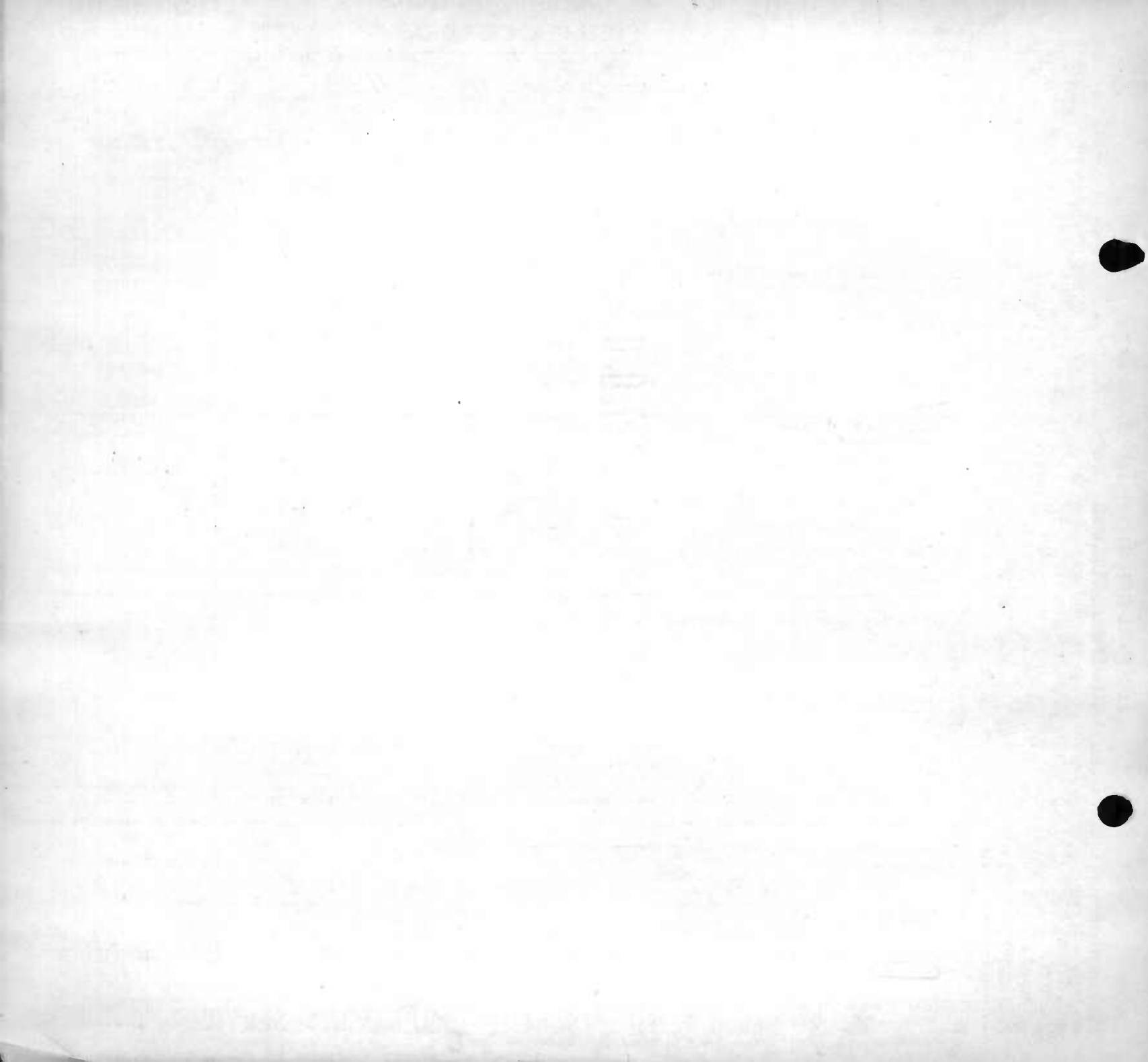
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | Registered No. 65 9609 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|---------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------|
| BIRTH NO. 65 9609 | | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | | 1. NAME OF DECEASED (Type or Print) SAUL WOLFOVITZ | | | |
| 2. DATE AND HOUR OF DEATH Sept 17 1965 10:20 A.M. | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION MT SINAI NURSING HOME | | | A. STATE MARYLAND B. COUNTY 15-12 | | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO | | | |
| | | | D. STREET ADDRESS (If rural, give location) 3825 PARK HEIGHTS AVE | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW | 8. DATE OF BIRTH NOV 15, 1895 | 9. AGE (In years last birthday) 69 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. | | 10B. KIND OF BUSINESS OR INDUSTRY CARPENTER | | 11. BIRTHPLACE (State or foreign country) POLAND | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME — | | | 14. MOTHER'S MAIDEN NAME — | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT SAMUEL WOLFOVITZ 6119 WESTERN BLVD | | |
| 18. 422.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) Pneumonia DUE TO (B) arteriosclerosis DUE TO (C) CVD | | INTERVAL BETWEEN ONSET AND DEATH 10 dy. 10 yr. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Net While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 17 1965 to Sept 17 1965 , that (I) (we) last saw the deceased alive on Sept 17 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | |
| 23A. SIGNATURE <i>[Signature]</i> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9/17/65 |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS M.D. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/19/65 | | 24C. NAME of CEMETERY or CREMATORY ROSEDALE | | 24D. LOCATION (City, town, or county) (State) BALTO MD |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Sylvester S. Lewis, Son | | ADDRESS 3319 Olympic Ave |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

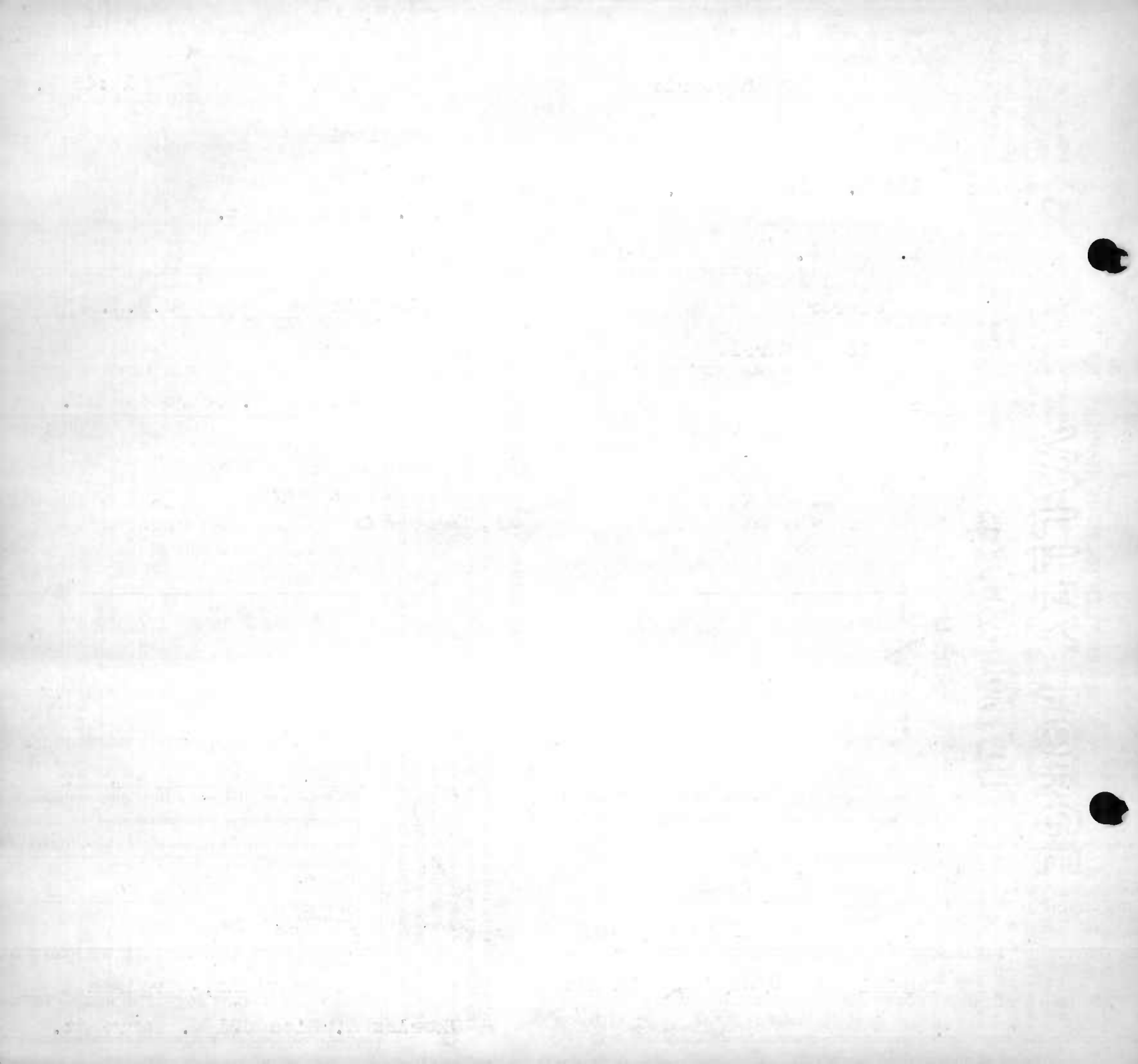
| BALTIMORE CITY HEALTH DEPARTMENT | | | | 65 9610 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------------|------------------------------------|-----------------------------------------------------------------------------------------|-------------------------------------------------------------|
| BIRTH NO. | | | | 65 9610 | |
| M.E. CASE NO. | | | | Registered No. | |
| 1. NAME OF DECEASED (Type or Print) MARION VANCE BRENNAN | | | | 2. DATE AND HOUR OF DEATH 9/13/65 11:45 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL | | (If not in hospital or institution, give street address or location) BALTIMORE, MARYLAND 21201 | | A. STATE MARYLAND B. COUNTY BALTIMORE | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) RUXTON | | D. STREET ADDRESS (If rural, give location) 1318 BERWICK ROAD | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED | 8. DATE OF BIRTH 9-11-95 | 9. AGE (in years last birthday) 70 yrs | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY | | 10B. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) NEW YORK | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME WILLIAM B. BRENNAN | | | |
| 14. MOTHER'S MAIDEN NAME MARY A. SULLIVAN | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | |
| 16. SOCIAL SECURITY NO. — | | 17. INFORMANT PATIENT | | ADDRESS AS ABOVE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION | | | | INTERVAL BETWEEN ONSET AND DEATH 9/11/65 (3 days) | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE. | | | | 20. UNKNOWN | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. NONE | | | | | |
| 19A. DATE OF OPERATION — | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED — | | 20A. AUTOPSY? (Yes or No) — | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) — | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) — | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) — | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? — | |
| 22. I certify that (4) (this hospital) attended the deceased from SEPT. 11, 1965 to SEPT. 13, 1965 , that (I) (we) last saw the deceased alive on SEPT. 13, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Margaret E. Lang | | | | 23B. DATE SIGNED 9/13/65 | |
| 23C. PHYSICIAN'S NAME (Type) MARGARET E. LANG | | 23D. ADDRESS UNIVERSITY HOSPITAL, BALTIMORE, MD. | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) SEP 17 1965 | | 24B. DATE SEP 17 1965 | | 24C. NAME OF CEMETERY or CREMATORY ANATOMY BOARD OF MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9611 | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 65 9611 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Herman Morris | | 2. DATE AND HOUR OF DEATH 9/18/65 12:45 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 18-02 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 116 N. Schroeder St. | | D. STREET ADDRESS (If rural, give location) 116 N. Schroeder St. | | | |
| 5. SEX M. | 6. RACE C. | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 5/8/03 | 9. AGE (In years last birthday) 62 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Mylo Morris | | 14. MOTHER'S MAIDEN NAME Lillie Jordan | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Odell Morris 116 N. Schroeder St. | |
| 18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) D - Hypertensive cardiovascular disease DUE TO (B) stroke DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from May 1958 to 9-18-1965 , that (I) (we) last saw the deceased alive on 9-18-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>did</u> (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. T. Torgot | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9-20-65 | |
| 23C. PHYSICIAN'S NAME (Type) TURGOT JEDDY. MD | | 23D. ADDRESS 549 N. Fulton Ave, | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/24/65 | | 24C. NAME of CEMETERY or CREMATORY Gallalee | |
| 24D. LOCATION (City, town, or county) (State) Branchville, Virginia | | 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR ADDRESS Charles A. Rice 661 W. Barre St. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributory cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. _____ | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|---------------------------------------------------------------------------|------------------------------|
| BIRTH NO. 65 9612 | | | | DATE AND HOUR OF DEATH 9/17/65 | | 9612 5:30 A.M. | |
| M.E. CASE NO. _____ | | | | 1. NAME OF DECEASED (Type or Print) William Furman | | | |
| 2. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital | | | | A. STATE MARYLAND | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 1031 McDONOUGH | | | |
| 5. SEX M 60 | 6. RACE C NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 11-11-04 | 9. AGE (In years last birthday) 60 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY Steel Co. | | 11. BIRTHPLACE (State or foreign country) Camden, S.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 13. FATHER'S NAME WILLIAM FURMAN | | 14. MOTHER'S MAIDEN NAME ELLEN BELTON | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. 213-09-1189 | | 17. INFORMANT MARGOLIA FURMAN | | | | ADDRESS 1031 MC DONOUGH ST. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 331XXI 260X | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO Pulmonary Embolus | | 5 min. | |
| ANTECEDENT CAUSES | | | | (B) DUE TO Cerebrovascular Accident | | 18 days. | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) _____ | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (this hospital) attended the deceased from 5/31 19 65 to 9/17 19 65 , that (we) last saw the deceased alive on 9/17 19 65 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE William H. Spencer III | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/17/65 | |
| 23C. PHYSICIAN'S NAME (Type) WILLIAM SPENCER III. | | | | 23D. ADDRESS Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-20-65 | | 24C. NAME of CEMETERY or CREMATORY Arbustus Memorial Pk. Arbustus, Md. | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | 25B. NAME OF REGISTRAR Robert E. Foxworth | | 25C. FUNERAL DIRECTOR Rendolph Collick | | ADDRESS 1412 E. Preston St. | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9613 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9613 | |
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| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) NEALEN = | | | | 2. DATE AND HOUR OF DEATH SEPT. 17 1965 | | 1:10 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 28-31 | | | |
| 5. SEX FEMALE | | | | 6. RACE WHITE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SISTER | | | | 10B. KIND OF BUSINESS OR INDUSTRY RELIGIOUS | | 8. DATE OF BIRTH August-3-1882 | |
| 13. FATHER'S NAME Theodore Nealen | | | | 14. MOTHER'S MAIDEN NAME Katherine Kirksch. | | 9. AGE (In years lost birthday) 85 82 | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. NONE | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 17. INFORMANT ST AGNES HOSPITAL CATON & WILKENS AVE. | | | | ADDRESS | | | |
| 18. 193.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Astrocytoma, grade IV - Parieto-occipital region on the left. (B) de IV - Parieto-occipital region on the left. (C) de IV - Parieto-occipital region on the left. | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from JULY 13 1965 to SEPT. 17 1965 , that (I) (we) last saw the deceased alive on SEPT 17 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE [Signature] | | | | M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/17/65 | |
| 23C. PHYSICIAN'S NAME (Type) DAFAEL H. MARIN. | | | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE Sept-21-65 | | 24C. NAME OF CEMETERY or CREMATORY SETON | | 24D. LOCATION (City, town, or county) (State) 6420 Reisterstown, Rd. 21215 | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Stewart & Bowen Co. | | ADDRESS 108-N-North-Av-21201 | |

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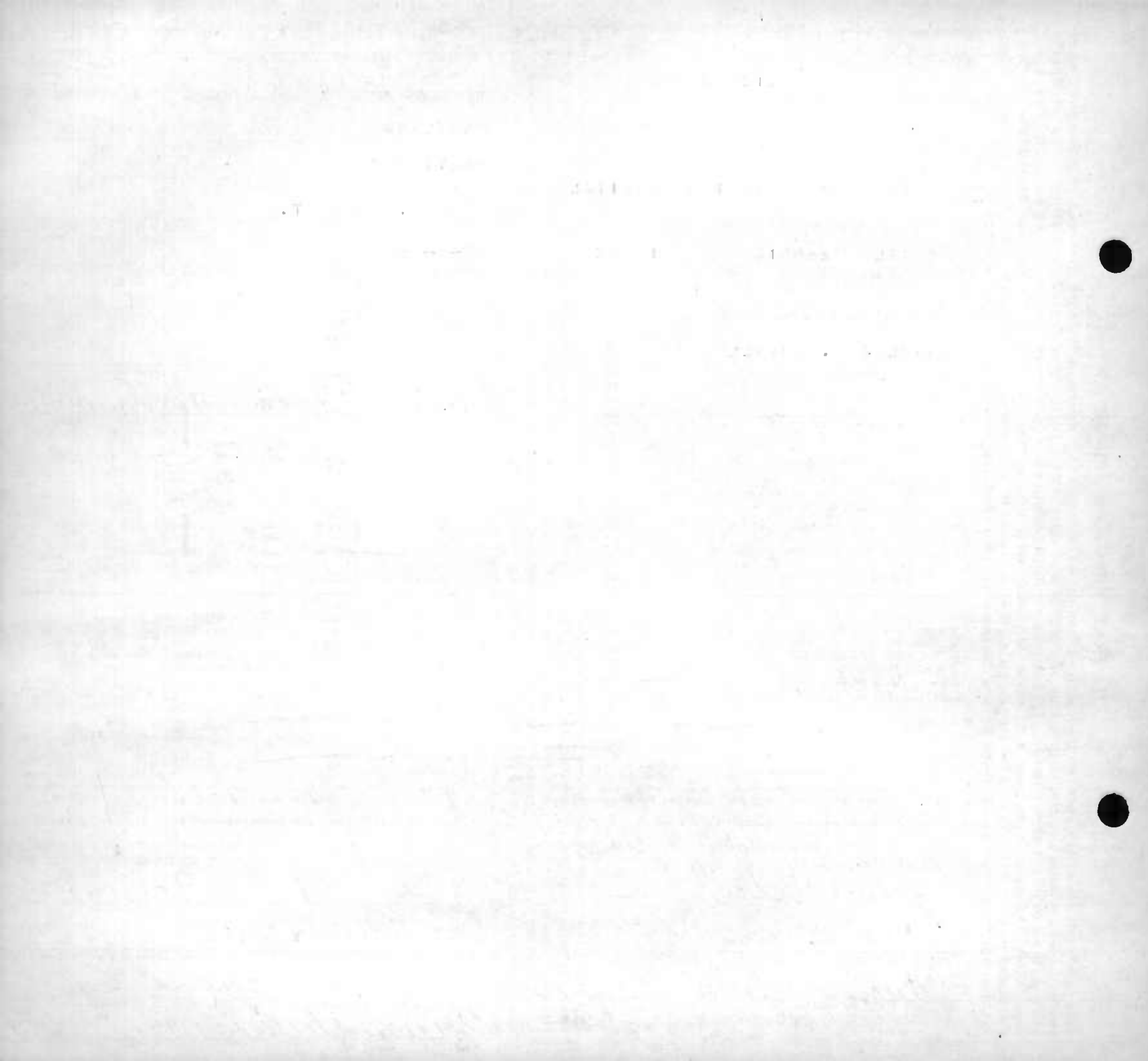
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

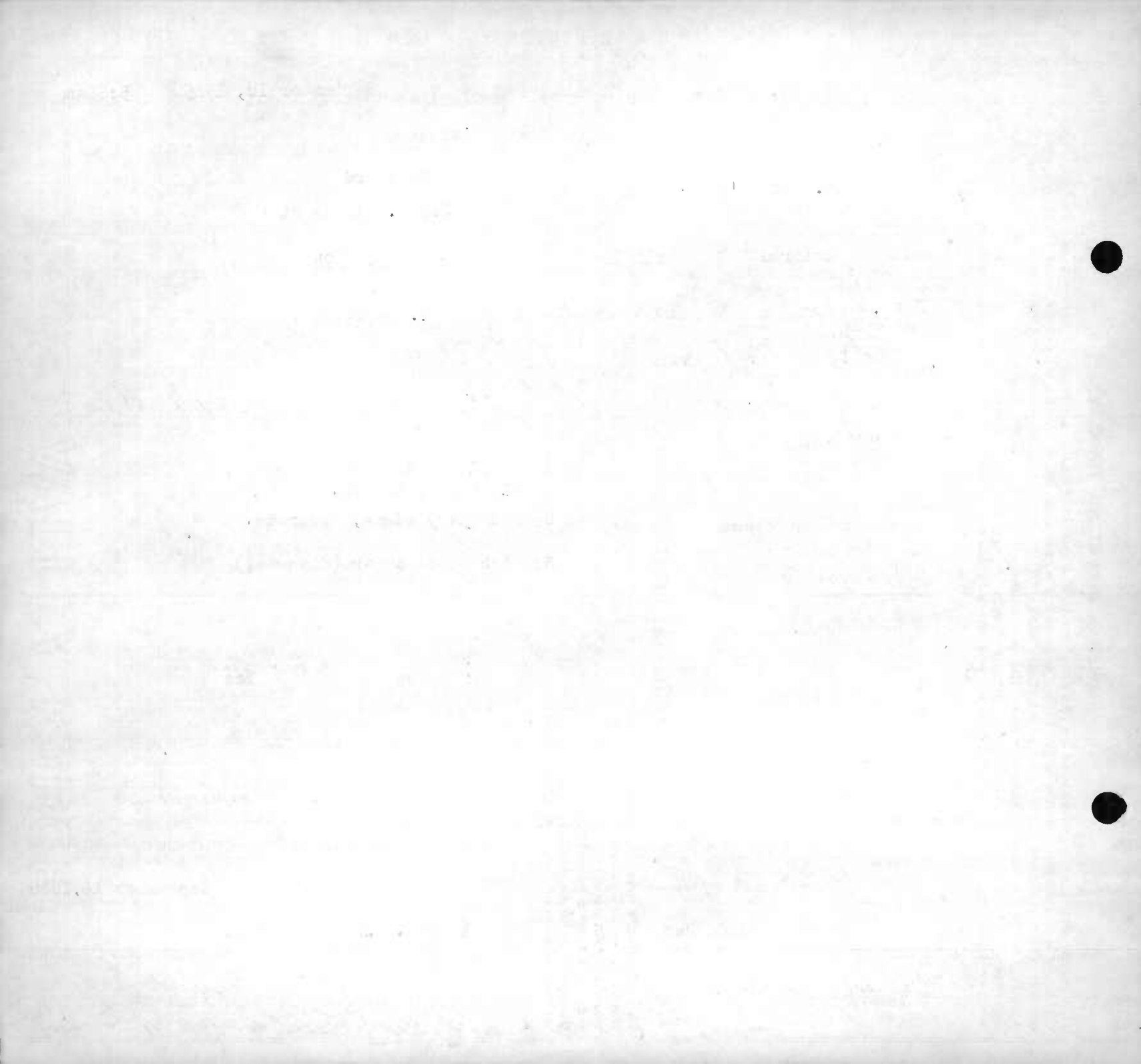
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | Registered No. 65 9614 | |
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| BIRTH NO. 65 9614 | | | | | | | | | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) ALICE GROSS | | | | | 2. DATE AND HOUR OF DEATH 9-18-65 4:30 P.M. | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 8-07 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1118 N. BOND ST. | | | | | | |
| 5. SEX FEMALE | 6. RACE NEGROID | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | | 8. DATE OF BIRTH 8-5-92 | 9. AGE (In years last birthday) 73 | If Under 1 Yr. Months: Days: Hours: Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | |
| 11. BIRTHPLACE (State or foreign country) Md. | | | | 12. CITIZEN OF WHAT COUNTRY? | | | | 13. FATHER'S NAME CHARLES W. DUVALL | | | |
| 14. MOTHER'S MAIDEN NAME Fannie | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT Artella Thompson | | | | ADDRESS 2518 W. Lanvale St | | | | 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Caecum of bladder c metastases | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | 20. CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH > 6 months | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Broncho pneumonia | | | | | | | | | | 21. INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| 19A. DATE OF OPERATION 2 NONE | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) | | | | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from 9-13 19 65 to 9-18 19 65 , that (I) (we) last saw the deceased alive on 9-18 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE John C. Wade | | | | | |
| 23B. PHYSICIAN'S NAME (Type) JOHN C. WADE | | 23C. ADDRESS JOHNS HOPKINS HOSPITAL | | 23D. DATE SIGNED 9-18-65 | | 23E. M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE SEP 20 1965 | | 24C. NAME OF CEMETERY or CREMATORY Bald Natl. Cemetery | | 24D. LOCATION (City, town, or county) (State) 5301 Fredrick Ave | | 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR Zorah G. Gluckson | | 25D. ADDRESS 1129 N. Caroline St. | | VS 150-REV. 1-1-65 | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

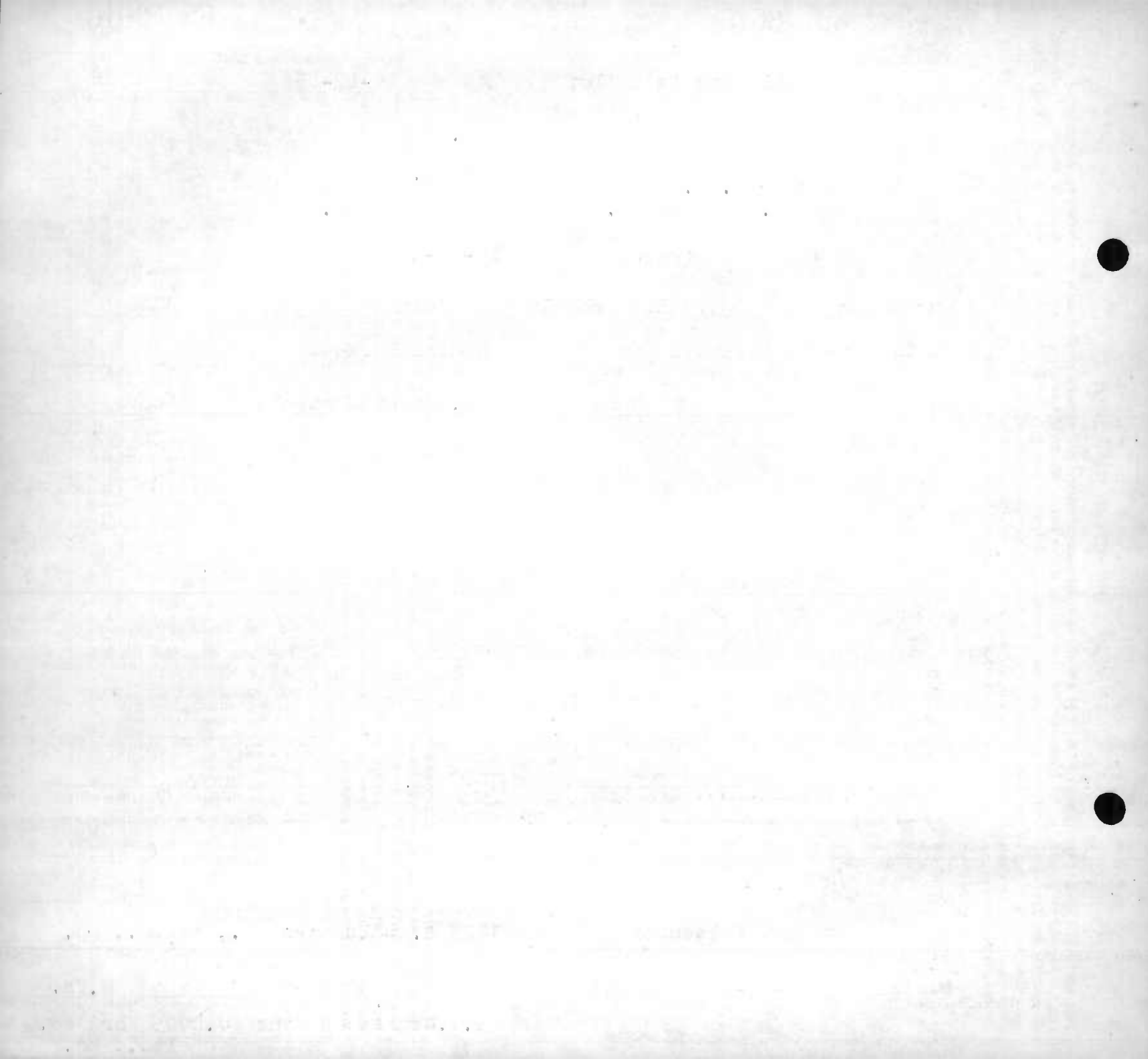
| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 65 9615 | | CERTIFICATE OF DEATH | | Registered No. 65 9615 | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|------------------------------------------------------------------------------------|-----------------------------|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------------------------|--|
| 1. NAME OF DECEASED (Type or Print) MASSIE, Andrew | | | | 2. DATE AND HOUR OF DEATH September 18, 1965 5:50am M. | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 8-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2213 E. Biddle St | | | | | | | |
| 5. SEX male | 6. RACE colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) single | 8. DATE OF BIRTH October 25, 1924 41 yrs | | 9. AGE (In years last birthday) | | 10. Under 1 Yr. Months Days | | 11. Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | | 10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel | | | | 11. BIRTHPLACE (State or foreign country) S. Carolina | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Robert Massie | | | | 14. MOTHER'S MAIDEN NAME Willie Bell | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes. World War #2 | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Thelma Reed | | | | ADDRESS 1025 N. Durham St | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 491X + 1260X | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) 1) Confluent lobular pneumonia, bilateral, severe. | | | | | | | |
| | | | | (B) 2) Pulmonary edema, moderate. | | | | | | | |
| | | | | (C) 3) High blood sugar (diabetes) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from September 17 19 65 to September 18 19 65 , that (I) (we) lost saw the deceased alive on September 18 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Govinda Rao | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED September 18, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Govinda Rao | | | | 23D. ADDRESS M.D. 1400 N. Caroline Street | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Sept 22/65 | | 24C. NAME of CEMETERY or CREMATORY Bened. Natl Cem. | | 24D. LOCATION (City, town, or county) (State) 5501 Frederick Ave. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | 25B. NAME OF REGISTRAR Robert E. Jackson | | 25C. FUNERAL DIRECTOR William E. Elickson | | ADDRESS 1129 N. Caroline St | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

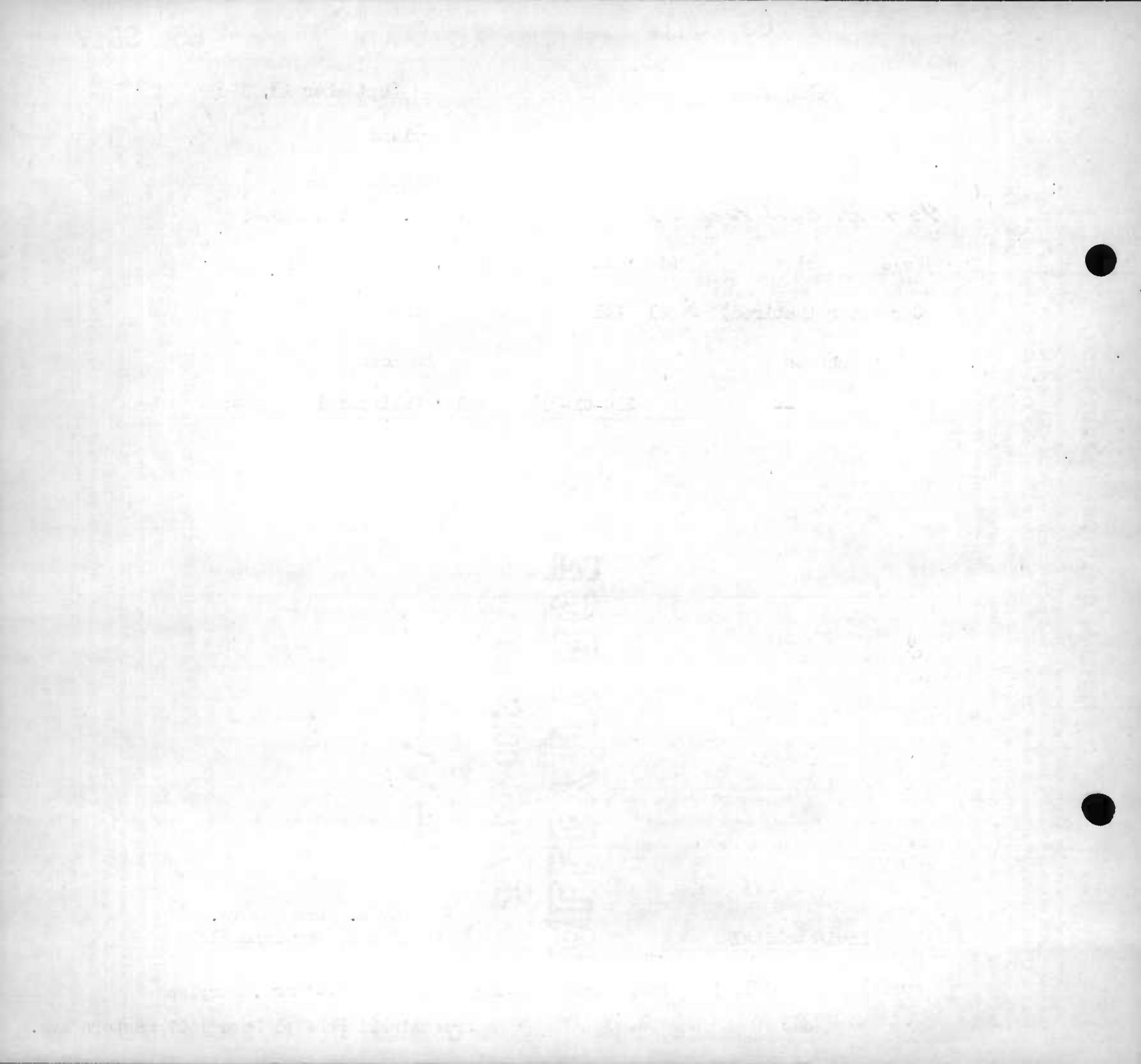
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9616 | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|---------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 65 9616 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Sophie Cassie Smiley | | 2. DATE AND HOUR OF DEATH 9-17-65 8 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 27-11 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Melchor N. H. 2327 N. Charles St. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. | | D. STREET ADDRESS (If rural, give location) 5002 York Rd. | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 12-20-1895 | 9. AGE (In years last birthday) 69 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian | | 10B. KIND OF BUSINESS OR INDUSTRY Public Schools | | 11. BIRTHPLACE (State or foreign country) Louisiana | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Toulme Victor Casanova | | 14. MOTHER'S MAIDEN NAME Louisa Burkett | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Mrs. James Whetsell | |
| | | | | ADDRESS Above | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Anteriorly (cardiac disease) | | CAUSE OF DEATH (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 20 years | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Carcinoma of Cervix | | 10 years | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) No | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 8 19 65 to Sept 17 19 65 , that (I) (we) last saw the deceased alive on Sept 17 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Stanley Felsenberg | | | | 23B. DATE SIGNED 9/17/65 | |
| 23C. PHYSICIAN'S NAME (Type) Stanley Felsenberg | | 23D. ADDRESS M.D. 1129 E. Baltimore St., Balto., Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9-20-65 | 24C. NAME of CEMETERY or CREMATORY Maplewood | 24D. LOCATION Kingwood | W. Va. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | 25B. NAME OF REGISTRAR Robert E. Jenkins | 25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

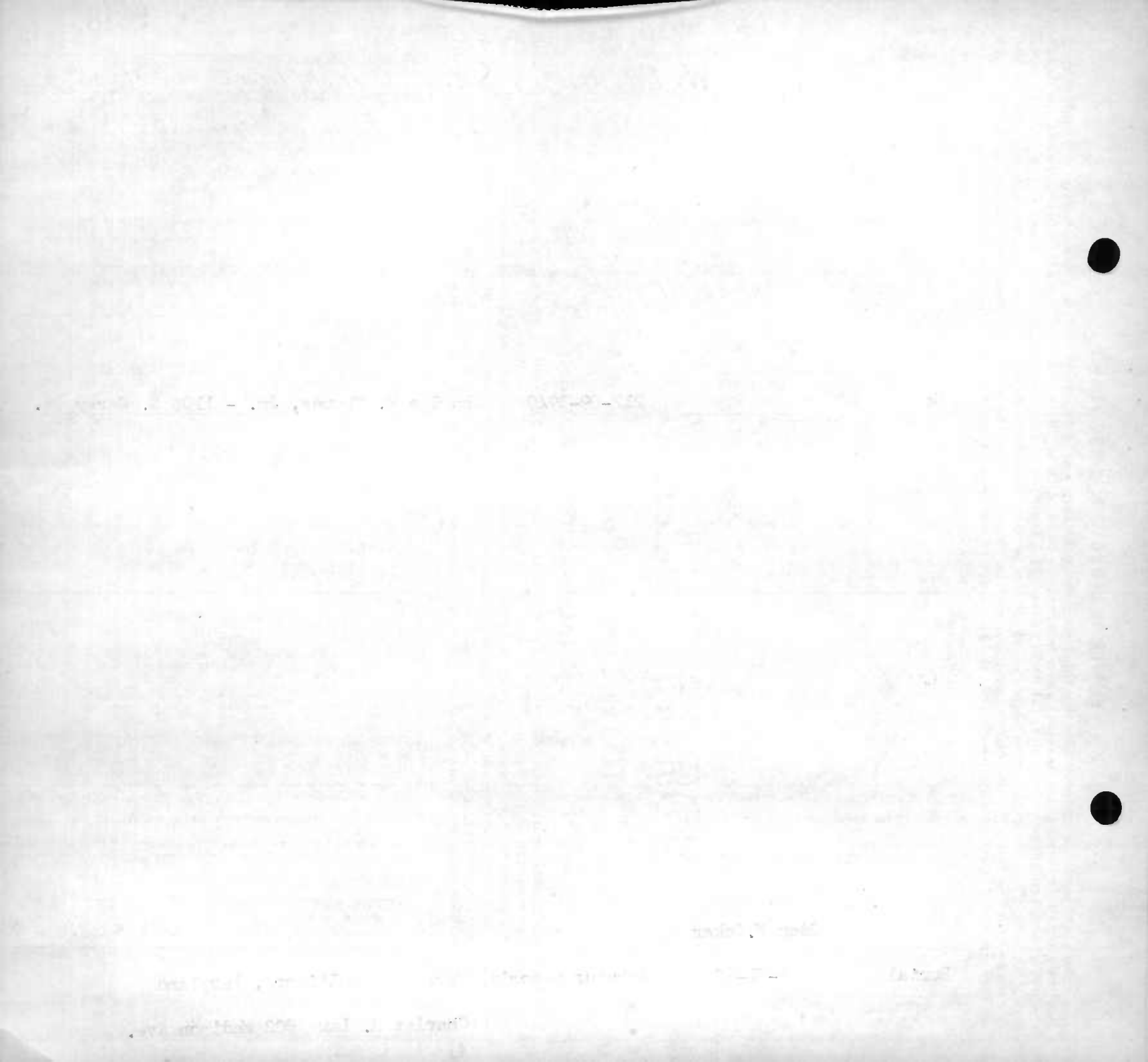
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9617 | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 65 9617 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | DATE AND HOUR OF DEATH September 18, 1965 49. M. | | | |
| 1. NAME OF DECEASED (Type or Print) JOHN JUST | | 2. DATE AND HOUR OF DEATH | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 444 N. CLINTON ST. | | A. STATE Maryland B. COUNTY 26-10 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 24 | | | |
| | | D. STREET ADDRESS (If rural, give location) 444 N. Clinton Street | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH May 3, 1880 | 9. AGE (In years last birthday) 85 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter (Retired) | | 10B. KIND OF BUSINESS OR INDUSTRY Steel Mill | | 11. BIRTHPLACE (State or foreign country) Poland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Unknown | | | |
| 14. MOTHER'S MAIDEN NAME Unknown | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No -- | | | |
| 16. SOCIAL SECURITY NO. 214-01-2148 | | 17. INFORMANT Helen Malinowski | | ADDRESS Same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) left hemiplegia generalized arterio-sclerosis | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 1 mo. | |
| 19. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from June 15, 1965 to Sept. 18, 1965 , that (I) (we) last saw the deceased alive on Sept. 17, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE L. E. Tobihal | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Sept. 20, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Louis Dobihal | | 23D. ADDRESS 447 N. Kenwood Ave. Baltimore, Maryland 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9/21/65 | 24C. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | 25B. NAME OF REGISTRAR Robert E. Faldut | | 25C. FUNERAL DIRECTOR Bruzdzinski Funeral Home 1407 Eastern Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. 65 9618 | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-----------------------------------------------------------------------------|----------------------------------------------------------|
| BIRTH NO. 65 9618 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) CHARLES W. THOMAS, SR. | | 2. DATE AND HOUR OF DEATH 9/17/65 9:00 p.m. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 1105 N. CAREY ST. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore MD | | | |
| | | D. STREET ADDRESS (If rural, give location) 15-47 | | | |
| 5. SEX M | 6. RACE C | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) withwed | 8. DATE OF BIRTH 3/29/89 | 9. AGE (In years last birthday) 76 | 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Chauffeur | | 11. BIRTHPLACE (State or foreign country) Matthew County, Va | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME John Thomas | | | |
| 14. MOTHER'S MAIDEN NAME Jennie Lynn | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. 212-09-3949 | | 17. INFORMANT Charles W. Thomas, Jr. - 1105 N. Carey St. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of Colon with metastasis to liver | | CAUSE OF DEATH (A) DUE TO Ca of prostate | | INTERVAL BETWEEN ONSET AND DEATH six months | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 8/5/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of Colon | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from June 1965 to Sept 17, 1965 , that (I) (we) last saw the deceased alive on Sept 17, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Odom N. Coker | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Sept 17, 65 | |
| 23C. PHYSICIAN'S NAME (Type) Odom N. Coker | | 23D. ADDRESS 3701 Liberty Heights Ave Balt. Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-21-65 | | 24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park | |
| 24D. LOCATION Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR Charles R. Law 802 Madison Ave. | | | |



BIRTH NO.

65 9619

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 9619

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

A.

SUSIE HUFFINGTON

2. DATE AND HOUR PRONOUNCED DEAD

9/16/65

12:20 p.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

626 W. Lafayette Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

626 W. Lafayette Ave.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

12-17-1885

9. AGE (In years
last birthday)

79

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Domestic

11. BIRTHPLACE (State or foreign country)

Jessup, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Chew

14. MOTHER'S MAIDEN NAME

Elizbeth Queen

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Shirley Chew, 1319 Madison Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) CARCINOMA OF RECTUM
DUE TO

(B) DUE TO

(C) DUE TO

I
ANTECEDENT CAUSESDISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic cardiovascular disease

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/17/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-20-65

23C. NAME OF CEMETERY or CREMATORY

Family Cemetery

23D. LOCATION

(City, town, or county)

Jessup, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

SEP 20 1965

24B. NAME OF REGISTRAR

Robert E. Farnham

24C. FUNERAL DIRECTOR

Charles R. Law, 802 Madison Ave.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. 65 9620 | | CERTIFICATE OF DEATH | | Registered No. 65 9620 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) CARL EISSELE | | 2. DATE AND HOUR OF DEATH 9-18-65 1:45 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 Sivan Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Baltimore B. COUNTY Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 5507 Benton Heights Ave | |
| 5. SEX Male | 6. RACE CAUCASIAN | 7. <input checked="" type="checkbox"/> MARRIED, NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 5-24-95 | 9. AGE (In years lost birthday) 70 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER - RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY INSURANCE | | 11. BIRTHPLACE (State or foreign country) WASHINGTON D.C. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME WILLIAM CARL EISSELE | | 14. MOTHER'S MAIDEN NAME FREDERICKA INSLEY | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W W I | | 16. SOCIAL SECURITY NO. 205-03-3937 | | 17. INFORMANT ADDRESS MARGARET R. EISSELE 5507 BENTON HEIGHTS AVE. | |
| 18. 4221 N 163X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ? CVA | | (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO AS CVD | | | |
| (C) | | | | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II Pneumonecctomy for Pulmonary CA - 5 yrs ago ? Abdominal Aneurism | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-18-65 to 9-18-65 that (I) (we) last saw the deceased alive on 9-18-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Gregorio Maffiori | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-18-65 | |
| 23C. PHYSICIAN'S NAME (Type) Gregorio Maffiori | | 23D. ADDRESS c/o Sivan Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/21/65 | | 24C. NAME of CEMETERY or CREMATORY DULANEY VALLEY | |
| 24D. LOCATION (City, town, or county) (State) YORK RD COCKEYSVILLE MD | | 25A. DATE RECD BY HEALTH DEPT. SEP 20 1965 | | 25B. NAME OF REGISTRAR Robert E. Finkbeiner | |
| 25C. FUNERAL DIRECTOR Doppel Bros Inc | | ADDRESS 7110 BELAIR RD | | | |

James H. H. H. H.

BALTIMORE

Mrs. C. C. C. C. C.

TO 2-14-12

MANAGER - RETIRED INSURANCE

WASHINGTON D.C.

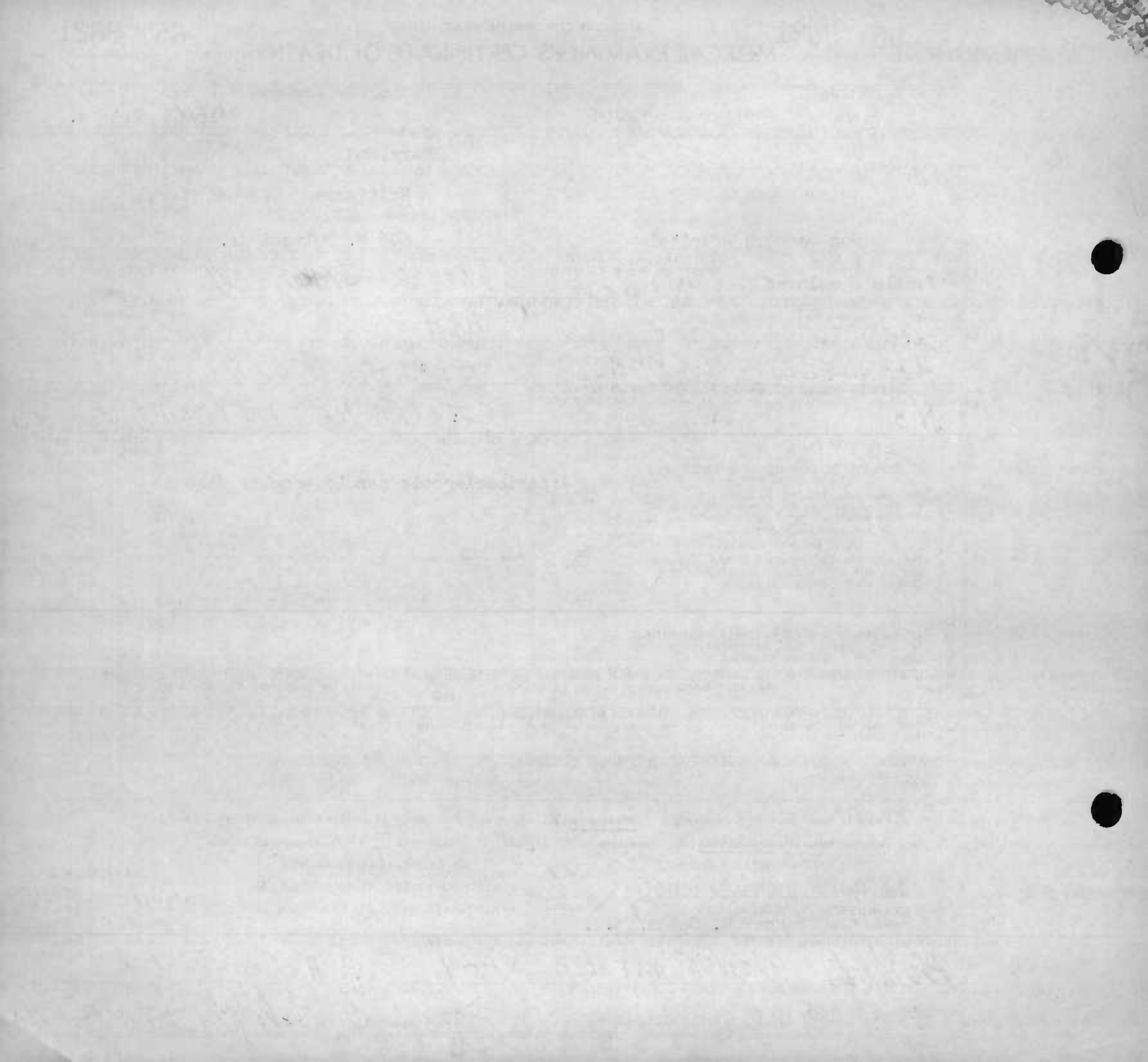
WILLIAM CARL FISKE

FREDERICKA FISKE

Yrs W W I

W-03-077 MARCART R. FISKE

| BIRTH NO. 65 9621 | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 9621 | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | Registered No. | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) ANNIE ROXIE LEWIS | | | | 2. DATE AND HOUR PRONOUNCED DEAD 9/18/65 2:35 a. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Bon Secours Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 506 N. Pulaski St. | |
| 5. SEX female | 6. RACE colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) WIDOW | 8. DATE OF BIRTH 11-2-1900-64 | 9. AGE (In years Birth day) | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Md. | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME PURNELL CEPHAS | | | 14. MOTHER'S MAIDEN NAME ELIZA ROSS | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Estelle Hill 115 CENTER ST DUNDALK Md | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 9/18/65 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE 9/21/65 | | 23C. NAME OF CEMETERY or CREMATORY Mt. CALVARY | |
| 23D. LOCATION (City, town, or county) (State) A.A. County Md | | 23E. NAME OF REGISTRAR Robert E. Farley, M.D. | | 23F. FUNERAL DIRECTOR Joseph E. Lock, Jr | |
| 24A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR 1304 N. Central | |



FUNERAL DIRECTOR: IMPORTANT

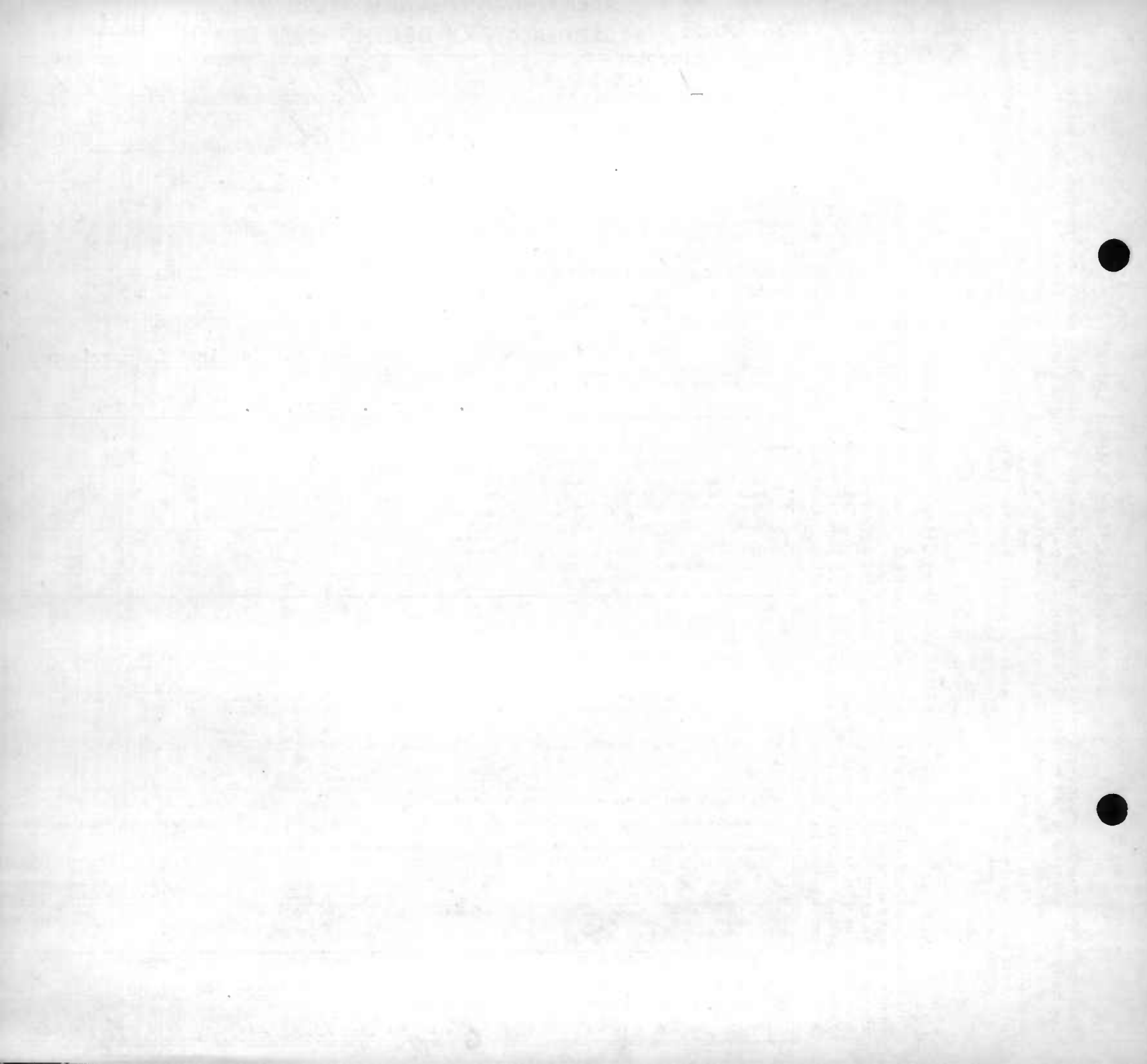
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9623 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9623 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Ruth Cheape</i> | | 2. DATE AND HOUR OF DEATH <i>Sept 18, 1965</i> <i>1125 P M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>(BALTIMORE)</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>REISTERSTOWN</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Johns Hopkins Hospital</i> | | O. STREET ADDRESS (If rural, give location) <i>BENSON LANE</i> | | 5300 | |
| 5. SEX <i>F</i> | 6. RACE <i>Cauc.</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i> | 8. DATE OF BIRTH <i>5-24-01</i> | 9. AGE (In years last birthday) <i>64</i> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Maine</i> | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME <i>Pierce</i> | | 14. MOTHER'S MAIEN NAME <i>MARY</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>John A. Cheape Benson Lane Reistertown</i> | |
| 18. <i>350X1</i> DISEASE OR CONOITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNOERLYING CONDITION last. | | CAUSE OF DEATH (A) <i>Sub Arachnoid Hemorrhage</i> DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <i>50 hours</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>None</i> | | | | | |
| 19A. DATE OF OPERATION <i>None</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9:30AM 9/18/1965</i> to <i>1125 PM 9/18 1965</i> , that (I) (we) last saw the deceased alive on <i>Sept. 18 1965</i> and that in (my) (our) apinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did nat) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Robert R. Kent</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Intern Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>Sept 18, 1965</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Robert R. Kent</i> | | 23D. ADDRESS <i>Johns Hopkins Hospital, Baltimore, Md.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Removal</i> | | 24B. DATE <i>9/21/65</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Riverview</i> | |
| 24D. LOCATION <i>Charlottesville, Va.</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 20 1965</i> | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Feltner</i> | | 25C. FUNERAL DIRECTOR <i>Wm. J. Lerner Sons Mba Balls 17 Md</i> | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9624 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9624 | |
| M.E. CASE NO. | | Dorothy | | | |
| 1. NAME OF DECEASED (Type or Print) | | HELEN MOORE | | 2. DATE AND HOUR OF DEATH 9/17/65 11 20/A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE Maryland | | B. COUNTY 13-07 | |
| CENTURY NURSING HOME | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | BALTIMORE, MD. | |
| BALTIMORE, MD. | | D. STREET ADDRESS (If rural, give location) | | 3632 KESWICK RD. 11 | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Nm Single | 8. DATE OF BIRTH 1/13/22 | 9. AGE (In years last birthday) 43 | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY Never Worked | | 11. BIRTHPLACE (State or foreign country) BALTO, MD. | |
| 13. FATHER'S NAME James David Moore | | 14. MOTHER'S MAIDEN NAME Nellie Virginia Harrison | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Mr. James D. Moore, Jr. 3632 Keswick Road | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 334X1 | | CAUSE OF DEATH (A) CEREBRAL PALSY DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from 7/22 to 9/17 1965, that (we) last saw the deceased alive on 9/17 1965 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Raymond Caplan | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9/17/65 | |
| 23C. PHYSICIAN'S NAME (Type) RAYMOND CAPLAN | | M.D. 23D. ADDRESS 1010 ST- PAUL ST. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9/20/65 | 24C. NAME OF CEMETERY or CREMATORY Loudon Park | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | 25B. NAME OF REGISTRAR John E. Faldut | | 25C. FUNERAL DIRECTOR Wm J. Tackner & Son Inc. & Palmer | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9625 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 9625 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) FRANCE PAULIE Algire | | 2. DATE AND HOUR OF DEATH 9-16-65 3:40 AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION BON SECOURS | | C. CITY OR TOWN (If outside city limits, write RURAL and give location) Catonsville MD. 53-00 | | | |
| (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If not, give location) 12 Nunnery Lane 28 | | | |
| 5. SEX FEMALE WHITE | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 11-17-879 | 9. AGE (In years last birthday) 85 | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) ARCADIA MD. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME Dr. THOMAS ALGIRE | | 14. MOTHER'S MAIDEN NAME RACHAEL JACKSON | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT ADDRESS Mrs. Ruth Addison Catonsville, Md. 28 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease or injury or complication which caused death.) PERITONITIS | | CAUSE OF DEATH Adenocarcinoma of cecum | | INTERVAL BETWEEN ONSET AND DEATH 2 days | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Atelectases of lungs; Hip Fracture | | 8 days | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 12 Nunnery Lane | |
| 21D. TIME OF INJURY (APPROX.) 9-5-65 11:30 | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? fell | |
| 22. I certify that (X) (this hospital) attended the deceased from 9-15-65 to 9-16-65 , that (X) (we) last saw the deceased alive on 9-16-65 and that (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE CPC. Linantini Jr. | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/16/65 | |
| 23C. PHYSICIAN'S NAME (Type) Released on approval | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/20/1965 | | 24C. NAME OF CEMETERY or CREMATORY St. Pauls Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Upperco, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | 25B. NAME OF REGISTRAR Robert E. Johnson | |
| 25C. FUNERAL DIRECTOR Wm. J. Tichenor & Son | | 25D. ADDRESS Baltimore, Md. | | | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

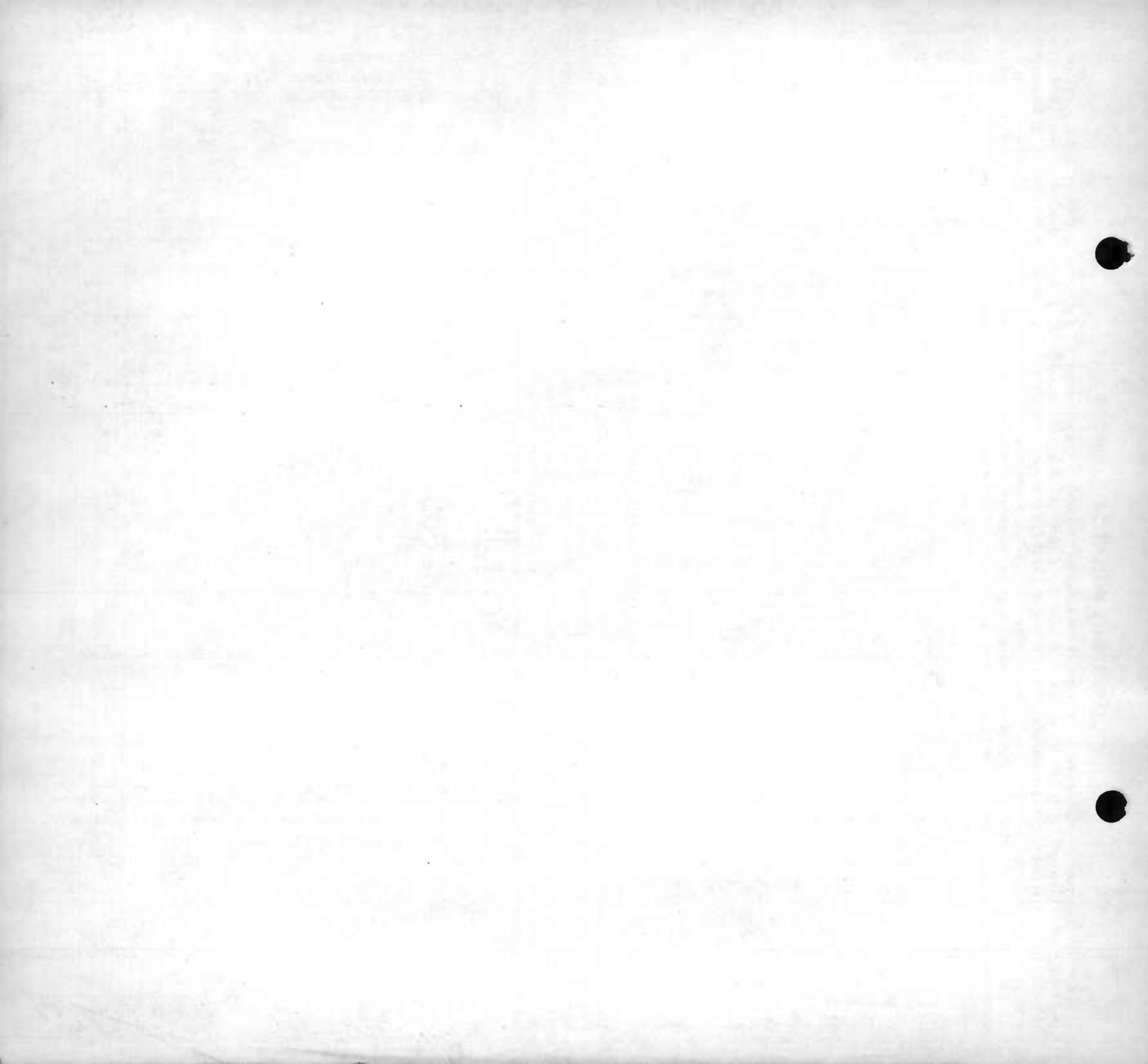
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| 1. NAME OF DECEASED (Type or Print) | | CONYERS BUTTON, JR. | | 2. DATE AND HOUR PRONOUNCED DEAD 9/18/65 3:15 p. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE Maryland B. COUNTY Baltimore | | | |
| Union Memorial Hospital | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hampton | | | |
| | | D. STREET ADDRESS (If rural, give location) 705 E. Seminary Ave. | | | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Nov. 4, 1920 | 9. AGE (In years last birthday) 44 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Engineer | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Philadelphia, Pennsylvania | |
| 13. FATHER'S NAME Conyers Button | | 14. MOTHER'S MAIDEN NAME Marie L. Dunham | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No None | | 16. SOCIAL SECURITY NO. 204-20-7092 | | 17. INFORMANT Mrs. Edward Frost | |
| 18. 4-22-1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | (A) DUE TO | | | |
| | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 9/19/65 | |
| | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Removal | | 23B. DATE 9/20/1965 | | 23C. NAME of CEMETERY or CREMATORY Ivy Hill Cemetery | |
| | | | | 23D. LOCATION (City, town, or county) (State) Philadelphia, Pennsylvania | |
| 24A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | 24B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 24C. FUNERAL DIRECTOR Wm. J. Fischer + Sons North + Pa. Ave. | |

WALLEN POLICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

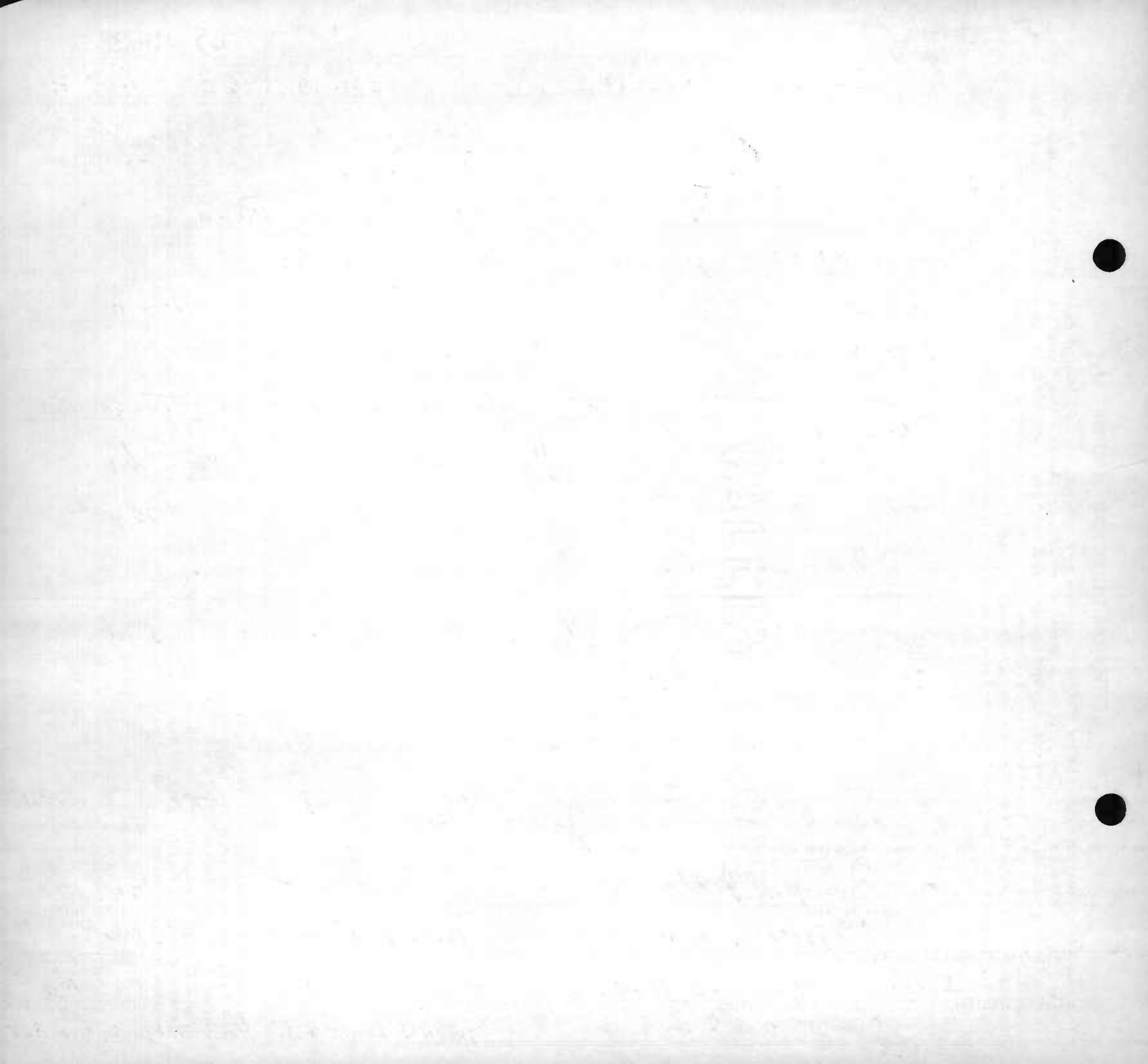
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9627 | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| <div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. _____</p> <p>M.E. CASE NO. _____</p> <p>1. NAME OF DECEASED (Type or Print) Nettie Hagger Zimmerman</p> </div> <div> <p>2. DATE AND HOUR OF DEATH September 18, 1965 8:15 P.</p> </div> </div> | | | | | |
| <p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Long Green Nursing Home</p> | | | <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE Maryland</p> <p>B. COUNTY 2804</p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore</p> <p>D. STREET ADDRESS (If rural, give location) 4508 Dunland Road 29</p> | | |
| <p>5. SEX Female</p> | <p>6. RACE White</p> | <p>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed</p> | <p>8. DATE OF BIRTH April 21, 1883</p> | <p>9. AGE (In years last birthday) 82</p> | <p>If Under 1 Yr. Months: Days: Hours: Min.</p> |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker</p> | | <p>10B. KIND OF BUSINESS OR INDUSTRY</p> | | <p>11. BIRTHPLACE (State or foreign country) Baltimore, Md.</p> | |
| <p>13. FATHER'S NAME Joseph Hagger</p> | | | <p>14. MOTHER'S MAIDEN NAME Sarah Allen</p> | | |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None</p> | | <p>16. SOCIAL SECURITY NO. 218-03-4292</p> | | <p>17. INFORMANT ADDRESS 1401 Cedarcroft Rd. Baltimore, Md. 12</p> | |
| <p>18. 4201 I CAUSE OF DEATH</p> <div style="display: flex;"> <div style="flex: 1;"> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> </div> <div style="flex: 1;"> <p>(A) DUE TO Coronary Occlusion</p> <p>(B) DUE TO Cerebral Vascular</p> <p>(C) unident Senility</p> </div> <div style="flex: 0.5;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div> | | | | | |
| <p>19A. DATE OF OPERATION 0</p> | | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> | | <p>20A. AUTOPSY? (Yes or No)</p> | |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p> | | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> | | <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> | |
| <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p> | | <p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> | | <p>21F. HOW DID INJURY OCCUR?</p> | |
| <p>22. I certify that (I) (this hospital) attended the deceased from Sept 8 1965 to Sept 18 1965. that (I) (we) last saw the deceased alive on Sept 18 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> | | | | | |
| <p>23A. SIGNATURE [Signature] M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/></p> | | | | <p>23B. DATE SIGNED 9/20/65</p> | |
| <p>23C. PHYSICIAN'S NAME (Type) M Paul Bjerly M.D.</p> | | | | <p>23D. ADDRESS 3870 York Rd</p> | |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p> | | <p>24B. DATE 9/21/1965</p> | | <p>24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery</p> | |
| | | <p>24D. LOCATION (City, town, or county) (State) Pikesville, Maryland</p> | | | |
| <p>25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965</p> | | <p>25B. NAME OF REGISTRAR Robert E. Farley</p> | | <p>25C. FUNERAL DIRECTOR ADDRESS Wm. J. Tichner - Sons Baltimore, Md. 17</p> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9628 | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 65 9628 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) SARAH PHILLIPS | | 2. DATE AND HOUR OF DEATH SEPT. 19, 1965 4 30 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospt. | | A. STATE MARYLAND B. COUNTY BALTO. | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 3300 | | | |
| | | D. STREET ADDRESS (If rural, give location) 3419 TULSA ROAD | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH DEC. 1884 | 9. AGE (In years last birthday) 80 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BRIGIA Latvia | |
| 13. FATHER'S NAME NOT KNOWN | | 14. MOTHER'S MAIDEN NAME Sophie | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS SANDRA MORSTEIN - 3419 TULSA RD. | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction | | CAUSE OF DEATH (A) DUE TO ASCVD | | INTERVAL BETWEEN ONSET AND DEATH 1 hr. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | 50 yrs | |
| (C) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Chronic Brain Syndrome | | 5 yrs | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Apr 1963 to Apr 1965 that (I) we last saw the deceased alive on June 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) we (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Joseph Shearman | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/20/65 | |
| 23C. PHYSICIAN'S NAME (Type) Joseph Shearman | | 23D. ADDRESS Agony Center Sinai Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/21/1965 | | 24C. NAME OF CEMETERY or CREMATORY WASHINGTON BLVD BALTO. | |
| 24D. LOCATION (City, town, or county) (State) MD | | 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | 25B. NAME OF REGISTRAR Robert E. Farber | |
| 25C. FUNERAL DIRECTOR SYLVAN S. LEWIS & SON, INC. | | ADDRESS 3319 OLYMPIA AVE | | | |



65 9629

BALTIMORE CITY HEALTH DEPARTMENT

65 9629

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)HOWARD L. ~~XXXXXXXX~~ MOFFETT

2. DATE AND HOUR PRONOUNCED DEAD

9/16/65 1:30 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE

Maryland

B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1804 W. Fayette St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

2/4/17

9. AGE (In years
last birthday)

48

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Brewery

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Joseph C Moffett

14. MOTHER'S MAIDEN NAME

Cora Hackleroad

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Cora Moffett, Same as line D

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)Craniocerebral injury with extensive
subdural hematoma

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B).....
DUE TO

(C).....

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

9/15/65

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

cerebral decompression

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Monroe and Fayette Sts.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
9 15 65 9:53p.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

apparently fell on back of head

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/16/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/18/65

23C. NAME of CEMETERY or CREMATORY

Loudon Park Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

SEP 20 1965

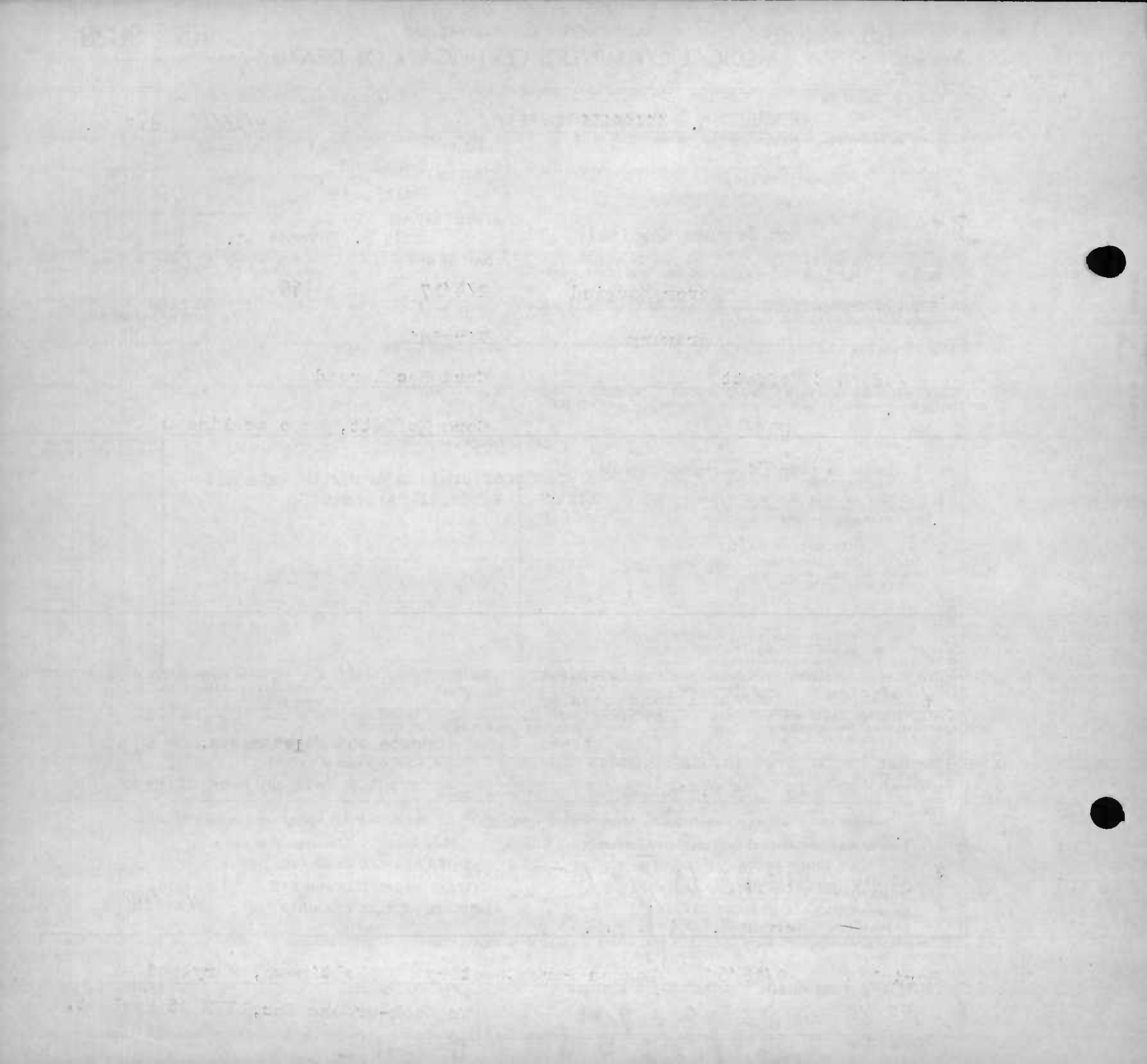
24B. NAME OF REGISTRAR

Robert E. Farber

24C. FUNERAL DIRECTOR

ADDRESS

Wm Cook-Brooks Inc, 1217 St Paul St.



9-15-65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9630 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9630 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) ROBERT GIBBS KEALEY | | | | 2. DATE AND HOUR OF DEATH Sept. 15, 1965 10:20 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION US Public Health Service Hospital Wyman Pk. Drive & 31st Street | | (If not in hospital or institution, give street address or location) | | A. STATE Md. | | B. COUNTY 9-03 | |
| 5. SEX M | | | | 6. RACE W | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) S/Sgt. retired | | 10B. KIND OF BUSINESS OR INDUSTRY USAF | | 8. DATE OF BIRTH 1/10/21 | | 9. AGE (In years last birthday) 44 | |
| 11. BIRTHPLACE (State or foreign country) Pa. | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME Jack W. Kealey | | | | 14. MOTHER'S MAIDEN NAME ? Janet Gibbs | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes USAF 1939-1945 | | | | 16. SOCIAL SECURITY NO. 214-20-5318 | | 17. INFORMANT Records- US PHS Hospital, Balto, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH Status operative hemorrhage from arteriovenous malformation of the left cerebral hemisphere, clinical | | INTERVAL BETWEEN ONSET AND DEATH Hours | |
| 19A. DATE OF OPERATION 9/15/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Arteriovenous hemangioma | | 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from Aug. 20 1965 to Sept. 15 1965, that (1) (we) last saw the deceased alive on Sept. 15 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Thomas J. Lau, Surgeon (R) | | | | 23B. DATE SIGNED 9/16/65 | | 23C. PHYSICIAN'S NAME (Type) Thomas J. Lau, Surgeon (R) | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/20/65 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore National | | 24D. LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Wm. Cook-Brooks Inc. | | 25D. ADDRESS 1217 St. Paul 1285 | |

CHITRAKOTI

1. 1. 1.

2. 2. 2.

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5. 5. 5.

6. 6. 6.

7. 7. 7.

8. 8. 8.

9. 9. 9.

10. 10. 10.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9631 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|--------------------------------------------------------------------------|-----------------------------|
| BIRTH NO. 65 9631 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MITCHELL JOHN | |
| 2. DATE AND HOUR OF DEATH 9/15/65 13 39 M. | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1-20-66 44 Union Memorial Hosp. | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD. B. COUNTY 27-01 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| D. STREET ADDRESS (If rural, give location) 4112 MARX AVE | | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) W | 8. DATE OF BIRTH 1880 2/7/79 | 9. AGE (In years last birthday) 86 85 | 10. Under 1 Yr. Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marine Surveyors | | 10B. KIND OF BUSINESS OR INDUSTRY John Mitchell - Son | | 11. BIRTHPLACE (State or foreign country) ENGLAND | |
| 12. CITIZEN OF WHAT COUNTRY? US | | 13. FATHER'S NAME JOHN MITCHELL | | | |
| 14. MOTHER'S MAIDEN NAME ELIZABETH RYDER | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK | | | |
| 16. SOCIAL SECURITY NO. 212-40-5347 | | 17. INFORMANT ADDRESS MITCHELL ALFRED SAME AS ABOVE | | | |
| 18. 293X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) MONOCYTIC ANEMIA DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 3 MOS | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ARTERIOSCLEROTIC VASC. DISEASE | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/30 19 65 to 9/15 19 65, that (I) (we) lost saw the deceased alive on 9/15 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Charles S. Brown | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/15/65 | |
| 23C. PHYSICIAN'S NAME CHARLES S. BROWN | | 23D. ADDRESS UNION MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-18-65 | | 24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery | |
| 24D. LOCATION Balto. Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR John C. Miller Inc. - 6415 Belair Rd. | |
| 25D. ADDRESS | | | | | |

Birth Certificate from England
showing correct birthdate
1-20-66 M.H.

CHARLES S. SPORN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------|
| BIRTH NO. 65 9632 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9632 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Mc Fee, Rita W. | | 2. DATE AND HOUR OF DEATH 9/17/65 11:50 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University of Maryland Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 5300 D. STREET ADDRESS (If rural, give location) 103 Thicket Road | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 9/25/95 | 9. AGE (In years last birthday) 69 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME William H. Winkelman | | 14. MOTHER'S MAIDEN NAME Anna S. Hall | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. C.W. Papy daughter ADDRESS 1712 CIRCLE ROAD RUXTON, MD. | |
| 18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Pulmonary Edema DUE TO (B) Hypertensive Cardiovascular Disease with DUE TO (C) Cardiac Decompensation | | INTERVAL BETWEEN ONSET AND DEATH 3 hrs. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cerebral thrombosis | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/16 19 65 to 9/17 19 65 , that (I) (we) lost saw the deceased alive on 9/17 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE William C. Wimmer M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) WIMMER | | 23D. ADDRESS University of Md. Hosp. Balt | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/20/65 | | 24C. NAME OF CEMETERY or CREMATORY DRUID RIDGE CEMETERY | |
| 24D. LOCATION (City, town, or county) (State) PIKESVILLE, MD. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | 25B. NAME OF REGISTRAR Robert E. T... | | 25C. FUNERAL DIRECTOR H.W. MEARS & SON | |
| ADDRESS 805 N. CALVERT ST. | | | | | |

11



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

65 9633

Registered No. 65 9633

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

FRANK G. THOMAS

2. DATE AND HOUR PRONOUNCED DEAD

9/17/65 6:40 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

University Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

816 Hollins St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

Oct. 21 1918

9. AGE (In years
last birthday)

46

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

OPERATOR ENGINEER

10B. KIND OF BUSINESS OR INDUSTRY

CONSTRUCTION Co.

11. BIRTHPLACE (State or foreign country)

Pa

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

GEO. F. THOMAS

14. MOTHER'S MAIDEN NAME

ELISE LANDIS THOMAS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

174-16-2017

17. INFORMANT

Edna BRAITHWAITE

ADDRESS

1325 Old North P.
Rd.

18.

422.1 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

PARTIAL

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREWerner U. Spitz, M.D.
EXAMINER'S NAME (Type)CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/18/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

9/20/65

23C. NAME OF CEMETERY or CREMATORY

Middlebrook Cem.

23D. LOCATION (City, town or county) (State)

Somerset County
Milford Township, Pa.

24A. DATE REC'D BY HEALTH DEPT.

SEP 20 1965

24B. NAME OF REGISTRAR

Robert E. Farber

24C. FUNERAL DIRECTOR

William R. Miller

ADDRESS

John A. Brubaker, Milford Township,
Somerset, Pennsylvania

VALLEY FOLIO

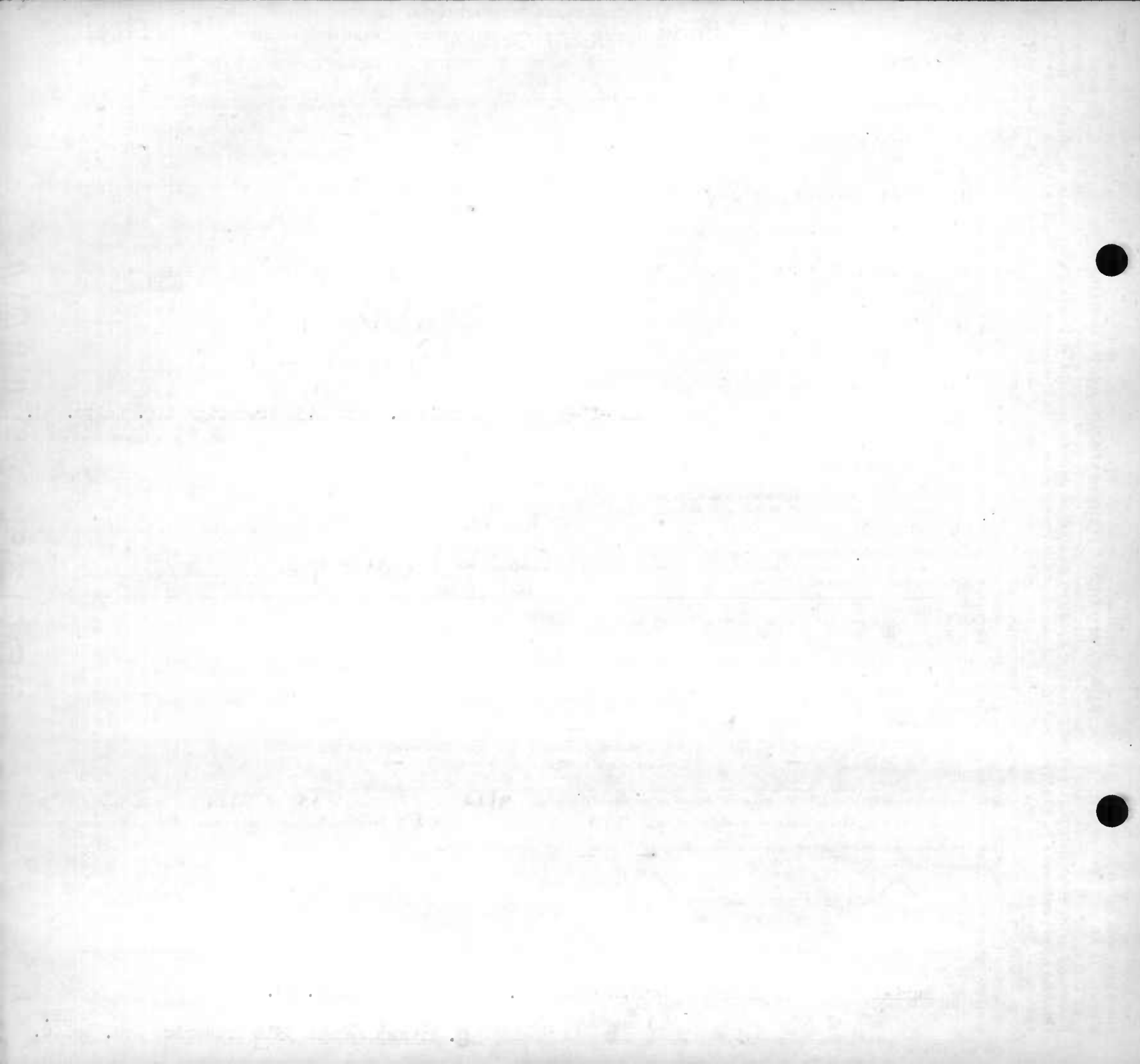
THE CONTENT

11/13/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------|--|----------------------------------|
| 65 9634 | | | | | CERTIFICATE OF DEATH | | Registered No. 65 9634 | | | |
| BIRTH NO. | | | | | M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Ruth Anna Hook</i> | | | | | 2. DATE AND HOUR OF DEATH <i>9/18/65 16:20 AM</i> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>20-04</i> | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>University Hospital</i> | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) <i>2438 Frederick Ave</i> | | | | | |
| 5. SEX <i>F</i> | 6. RACE <i>white</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i> | 8. DATE OF BIRTH <i>8/9/99</i> | 9. AGE (In years last birthday) <i>65</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>-</i> | | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | |
| 13. FATHER'S NAME <i>Andrew Bach</i> | | | | | 14. MOTHER'S MAIDEN NAME <i>Margaret Carter</i> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. <i>217-14-5988</i> | | 17. INFORMANT <i>Charles A. Hook</i> | | | ADDRESS <i>2438 Frederick Ave. Balto. Md.</i> | | |
| 18. <i>175.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | CAUSE OF DEATH (A) <i>?</i> DUE TO (B) <i>Ascites</i> DUE TO (C) <i>Carcinoma of right salpinx & metastasis</i> | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | |
| 19A. DATE OF OPERATION <i>9/13/65</i> | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Ascites</i> | | | 20A. AUTOPSY? (Yes or No) <i>NO</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>NO</i> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>-</i> | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>-</i> | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>-</i> | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? <i>-</i> | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9/12</i> 19 <i>65</i> to <i>9/18</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>9/18</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | |
| 23A. SIGNATURE <i>Rosevelt Taylor Jr.</i> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED <i>9/18/65</i> | | |
| 23C. PHYSICIAN'S NAME (Type) <i>Rosevelt Taylor Jr.</i> | | | | | 23D. ADDRESS <i>M.D.</i> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>9/21/1965</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Loudon Park Cem.</i> | | | 24D. LOCATION (City, town, or county) (State) <i>Balto. Md.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 20 1965</i> | | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | | 25C. FUNERAL DIRECTOR ADDRESS <i>G. Truman Schwab 3512 Frederick Ave. Balto. Md.</i> | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9635 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9635 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------|------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------------|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Roland W. Adams | | | | 2. DATE AND HOUR OF DEATH Sept. 16, 1965 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE Maryland | | B. COUNTY 25-41 | |
| 3616 Coolidge Ave. | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 3616 Coolidge Ave. | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH June 11, 1897 | 9. AGE (In years lost birthday) 68 | 11. BIRTHPLACE (State or foreign country) Washington D.C. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk | | | 10B. KIND OF BUSINESS OR INDUSTRY F.A. Davis Co. | | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Martin Adams | | | | 14. MOTHER'S MAIDEN NAME Florence Ireland | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or Unknown) (If yes, give war or dates of service) Yes 1917-1919 | | 16. SOCIAL SECURITY NO. 215-03-6964 | | 17. INFORMANT Mrs. Ethel L. Adams | | ADDRESS Balto. Md. 21229 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of Lung | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 2 yrs | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 1963 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 2 19 63 to Sept 16 19 65 that (I) (we) last saw the deceased alive on Sept 15 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Charles A Cahn | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9/17-65 | |
| 23C. PHYSICIAN'S NAME (Type) Charles A CAHN | | | | 23D. ADDRESS 2145 W Baltimore St | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Sept. 20, 1965 | | 24C. NAME of CEMETERY or CREMATORY Balto. Nat. Cem. | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR G. Truman Schwab | | ADDRESS 3512 Frederick Ave. Balto. Md. | |

Government of England

1763

July 15/63

Robert B. Cook

Charles A. Cahn

215 N. Boston St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------|--|
| 65 9636 | | CERTIFICATE OF DEATH | | 65 9636 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Suipis, Alvina (Mrs. Rudolph) | | 9/16/65 4:45 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| The Union Memorial Hospital | | Maryland Baltimore | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | |
| Female | | white | | | |
| 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | 10. CITIZEN OF WHAT COUNTRY? | |
| 7-11-10 | | 55 | | LATVIAN | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | Nurses Aid | | Latvia | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| John Zeltins | | Anna | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | 326-28-3879 | | Mr. Rudolph Suipis Same as above | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | 3 years | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | | |
| 22. I certify that (this hospital) attended the deceased from 9-13 1965 to 9-16 1965, that (we) lost saw the deceased alive on 9-16 1965 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| A. C. Tipton Jr. | | 9/16/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| ANCEL C. TIPTON, JR. | | The Union Memorial Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 9/18/1965 | | Woodlawn Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| SEP 20 1965 | | Robert E. Fairbank | | Eugenia K. Seitz 5209 York Road Balto. Md. 21212 | |

ALL C. F. P. 1, 2.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9637 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9637 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------|-----------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-----------------------------------------------------------------------|--|
| 1. NAME OF DECEASED (Type or Print) <i>DuBois, Herbert</i> | | | | 2. DATE AND HOUR OF DEATH <i>9/14/65 12 NOON</i> | | | |
| 3. PLACE OF DEATH-IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Sinai Hospital of Baltimore, Inc</i> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>V-M</i> B. COUNTY <i>V-M</i> C. CITY OR TOWN (If, outside city limits, write RURAL and give township) <i>Washington, D.C.</i> D. STREET ADDRESS (If rural, give location) <i>221 E 22 St. S.E.</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Single</i> | 8. DATE OF BIRTH <i>4/9/93</i> | 9. AGE (In years last birthday) <i>72</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind or work done during most of working life, even if retired) <i>Retired</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>U.S. Govt</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Moses DuBois</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Meriam Friedel</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. <i>153.3 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Ob of sigmoid c obstruction</i> | | | | CAUSE OF DEATH (A) <i>Massive Aspiration</i> DUE TO (B) <i>Severe Peritonitis</i> DUE TO (C) <i>Ruptured Cecum</i> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION <i>1 9/10/65</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>above</i> | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9/10</i> 19 <i>65</i> to <i>9/14</i> 19 <i>65</i> , that (I) (we) lost saw the deceased alive on <i>9/14</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Hideki Sakurai</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED <i>9/14/65</i> | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>Dr. Hideki Sakurai</i> | | | | 23D. ADDRESS <i>Sinai Hospital</i> | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>9/17/65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Arlington Hall</i> | | 24D. LOCATION (City, town, or county) (State) <i>Farm Myer, Va</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 20 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Farker</i> | | 25C. FUNERAL DIRECTOR <i>Robert D. Mattingly</i> | | ADDRESS <i>131-11th St. SE</i> | |

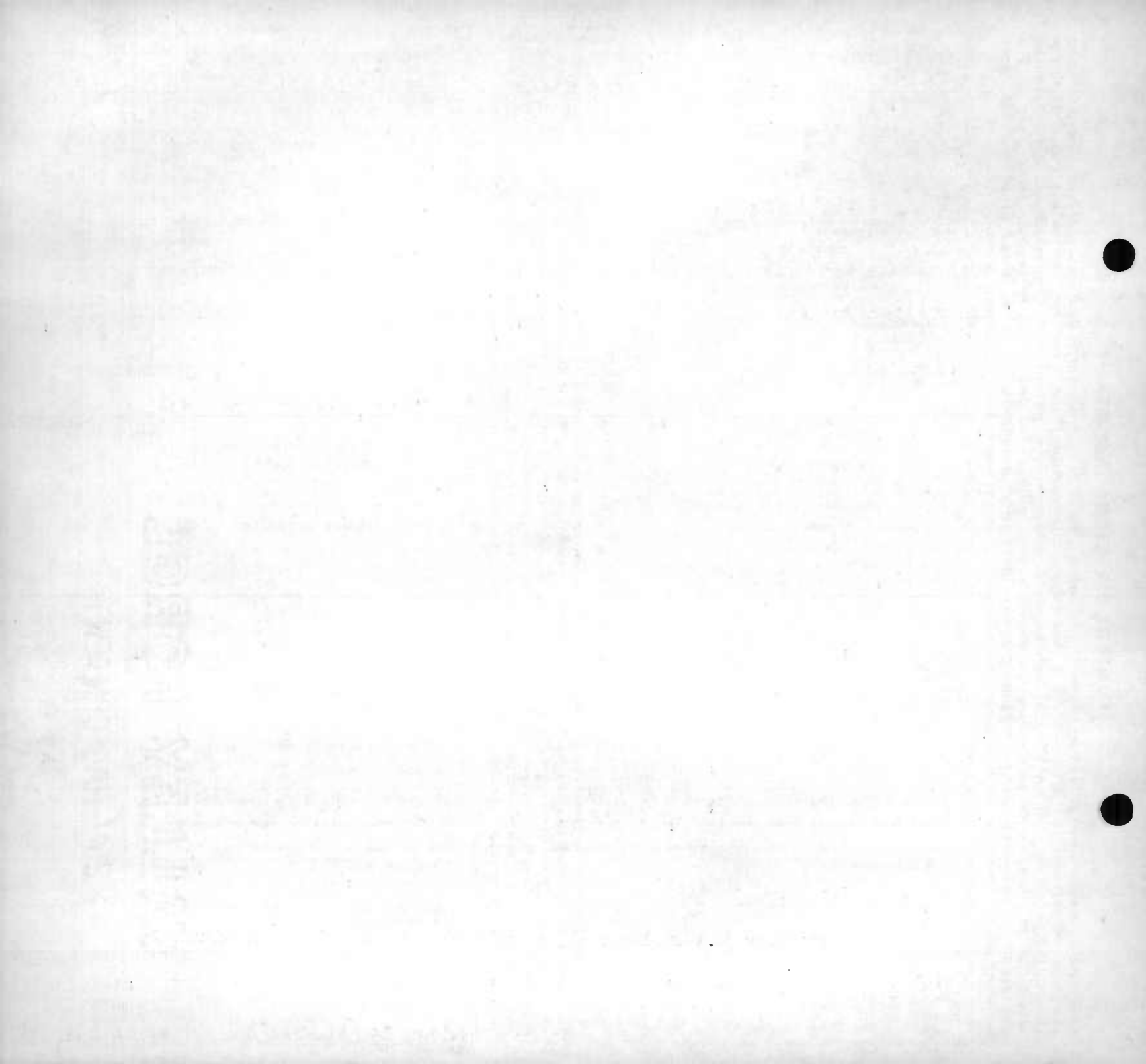
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FUNERAL DIRECTOR: IMPORTANT

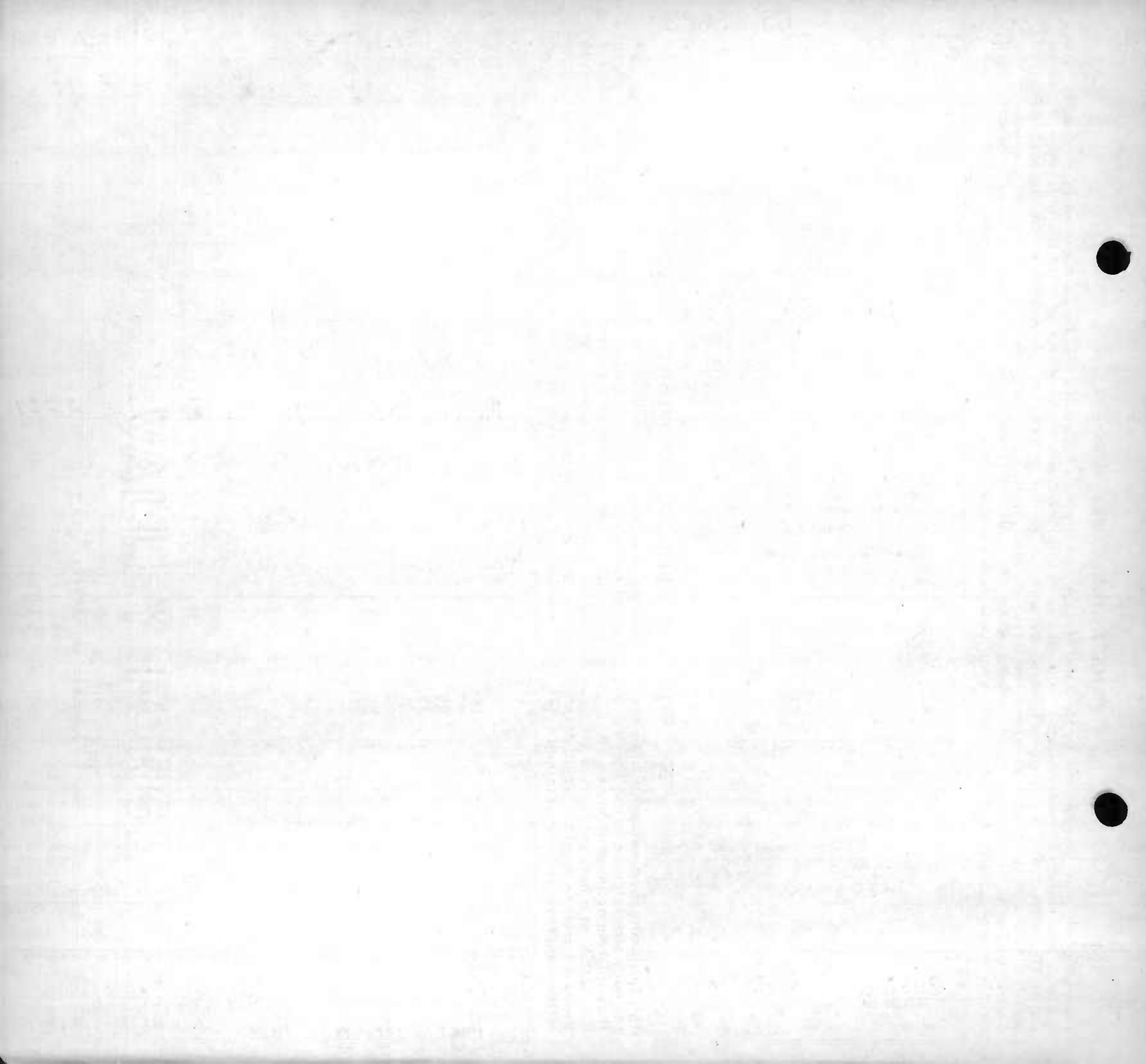
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9638 | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) HERMAN RICHARDSON | | | | 2. DATE AND HOUR OF DEATH 9/14/65 11:45 P.M. | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital | | | | A. STATE Maryland | | | | B. COUNTY Baltimore | | | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Church Creek | | | | 5900 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) P.O. Box 14 | | | | | | | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH 3/11/96 | | 9. AGE (In years last birthday) 69 | | 10. If Under 1 Yr. Months Days | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired merchant | | 10B. KIND OF BUSINESS OR INDUSTRY Petroleum | | 11. BIRTHPLACE (State or foreign country) CHURCH CREEK, MD | | | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | | | |
| 13. FATHER'S NAME Howard Richardson | | | | 14. MOTHER'S MAIDEN NAME Ada L. Airey | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT HOSPITAL RECORDS | | | | ADDRESS | |
| 18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) acute pulmonary edema DUE TO (B) arteriosclerotic heart disease DUE TO (C) | | | | INTERVAL BETWEEN ONSET AND DEATH 2-4 days | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from September 10 19 65 to September 14 19 65 , that (I) (we) lost saw the deceased alive on September 14 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Charles T. Kaelber | | | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/15/65 | |
| 23C. PHYSICIAN'S NAME (Type) Charles T. Kaelber | | | | 23D. ADDRESS The Johns Hopkins Hospital | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/18/65 | | 24C. NAME OF CEMETERY OR CREMATORY DORCHESTER MEMORIAL PARK | | 24D. LOCATION (City, town, or county) (State) CAMBRIDGE, MD | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Legompte Funeral Home | | ADDRESS CAMBRIDGE, MD | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

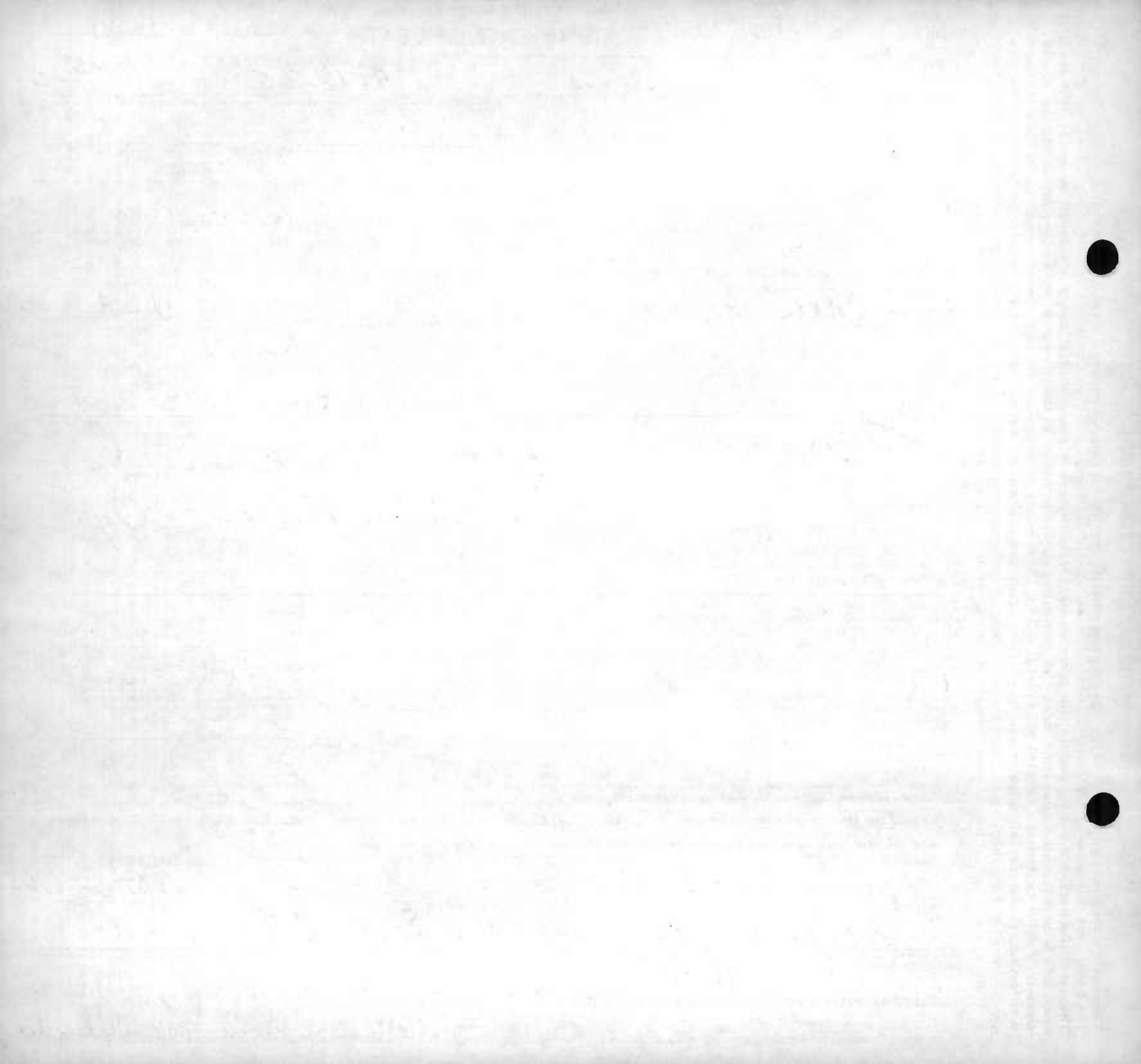
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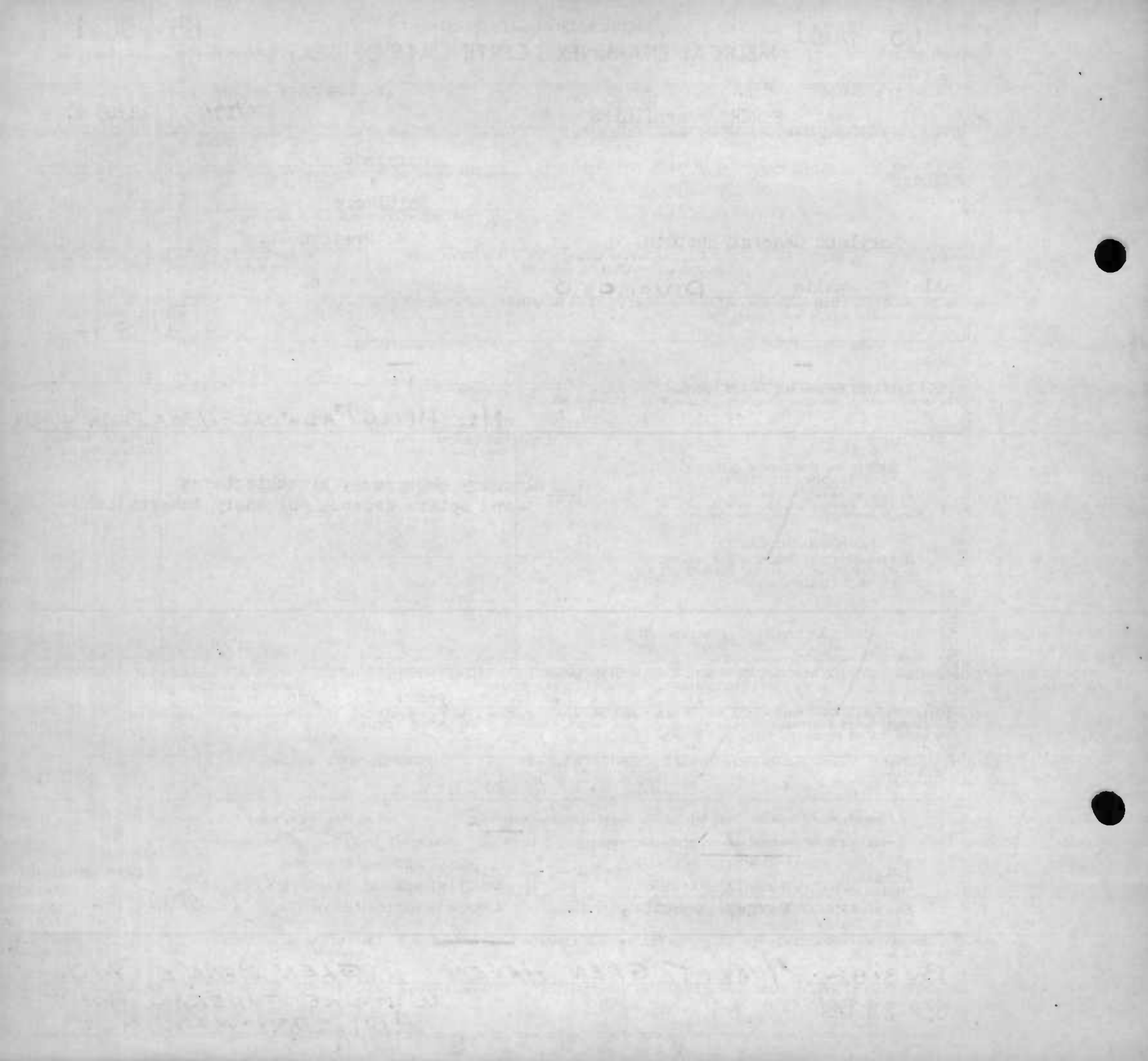
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|--------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|--------------|--------------------------------------|--|
| 65 9640 | | | | | Registered No. 65 9640 | | | | |
| BIRTH NO. | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>MR. OLIVER BROWN</i> | | | | | 2. DATE AND HOUR OF DEATH <i>9-16-65 4:45 A.M.</i> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | | A. STATE | | B. COUNTY | | |
| <i>Bon Secours Hospital</i> | | | | | <i>Maryland</i> | | <i>27-48</i> | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | |
| | | | | | <i>Baltimore 21212</i> | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) | | | | |
| | | | | | <i>708 St. Dunstons Road</i> | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| <i>M</i> | <i>W</i> | <i>MARRIED</i> | | <i>12/21/20</i> | <i>44</i> | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| <i>Liquor Clerk</i> | | | | | | <i>New Jersey</i> | | <i>USA</i> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| <i>Robert Brown</i> | | | | <i>Blanche</i> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| <i>No</i> | | | | | | <i>Minnie R. Brown 708 St. Dunstons Rd</i> | | | |
| 18. <i>491X 1</i> | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) | | | | <i>Bilateral Bronchopneumonia</i> | | | | <i>Days</i> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | <i>and Delirium Tremens</i> | | | | <i>days</i> | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| <i>2</i> | | | | <i>Yes</i> | | <i>Yes</i> | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9-14-65</i> to <i>9-16-65</i> , that (I) (we) last saw the deceased alive on <i>9-16-65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>Agustin del Campo</i> M.D. | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED <i>Sept 16-1965</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>AGUSTIN DEL CAMPO</i> M.D. | | | | | 23D. ADDRESS <i>Bon Secours Hosp Balto Md</i> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| <i>Burial</i> | | <i>9/20/65</i> | | <i>Dulaney Valley Mem. Garden</i> | | <i>Dulaney Valley, Md.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | |
| <i>SEP 20 1965</i> | | <i>Robert S. Fisher</i> | | <i>Harvard Funeral Home</i> | | <i>4107 Wilkins Ave</i> | | | |



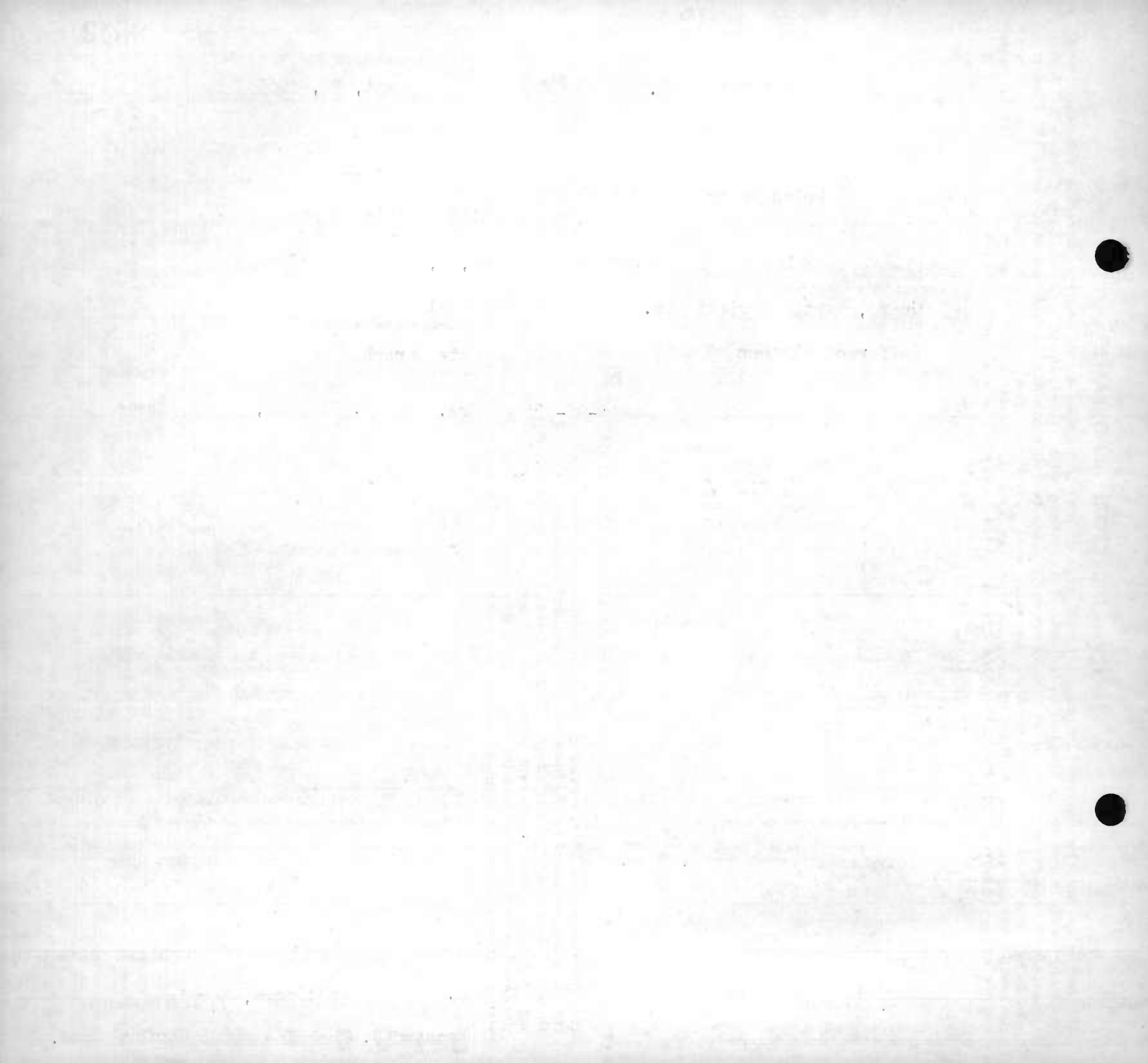
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|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|
| 65 9641 | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 9641 | |
| BIRTH NO. | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | BERCH PHILLIPS | | 2. DATE AND HOUR PRONOUNCED DEAD 9/10/65 11:05 a. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland | | B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | | D. STREET ADDRESS (If rural, give location) 9 W. Preston St. | |
| 5. SEX male | | 6. RACE white | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED | |
| 8. DATE OF BIRTH 61 | | 9. AGE (In years last birthday) 61 | | 10. If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS MRS. HELEN CADWELL-4303 ELDONE RD. | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. INTERVAL BETWEEN ONSET AND DEATH | | (A) Pulmonary emphysema, bronchiectases and active caseous pulmonary tuberculosis XXXXX | | | |
| (B) DUE TO | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 9/10/65 | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. | | M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 23B. DATE 9/18/65 | | 23C. NAME OF CEMETERY GLEN HAVEN | |
| 24A. DATE REC'D BY HEALTH DEPT. SEP 20 1965 | | 24B. NAME OF REGISTRAR Robert E. Spitz, M.D. | | 24C. FUNERAL DIRECTOR ADDRESS WITZKE FUNERAL HOME 4101 EDMONDSON AVE. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9642 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9642 | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------------------------|-----------------------|----------------------------------------------------------------------|----------------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| Lawrence M. Fischer | | | | Sept. 20, 1965 1 A M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| Union Memorial Hospital | | | | Maryland | | 27-05 | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | Baltimore | | | |
| D. STREET ADDRESS (If rural, give location) | | | | 3118 Rosalie Avenue | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months | | If Under 24 Hrs. Days Hours Min. |
| male | white | married | Aug. 5, 1905 | 60 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Guard, Martin Marietta Co. | | | | Maryland | | U S A | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Jefferson Fischer | | | | Kate Frank | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| | | 215-05-1352 | | Mrs. Anna L. Fischer. | | same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | | instantly | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | 20 months | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO | | 20 months | |
| | | | | Myocardial Infarction | | | |
| | | | | Coronary Arteriosclerosis | | | |
| | | | | Acute Pericarditis | | | |
| | | | | Coronary Insufficiency | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | Pulmonary Emphysema | | 3 yrs. | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) this hospital attended the deceased from 2/10 1964 to 9/19 1965, that (I) was last saw the deceased alive on 9/18 1965 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was did not view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | | | 23B. DATE SIGNED | |
| John H. Hirschfeld M.D. | | | | | | 9/20/1965 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| JOHN H. HIRSCHFELD M.D. | | | | 6919 HARFORD ROAD BALTIMORE 34 Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 9/23/65 | | Gardens of Faith Cem. | | Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| SEP 20 1965 | | Robert E. Fisher | | Leonard J. Buck Inc | | 5305 Harford Road. | |



FUNERAL DIRECTOR: IMPORTANT

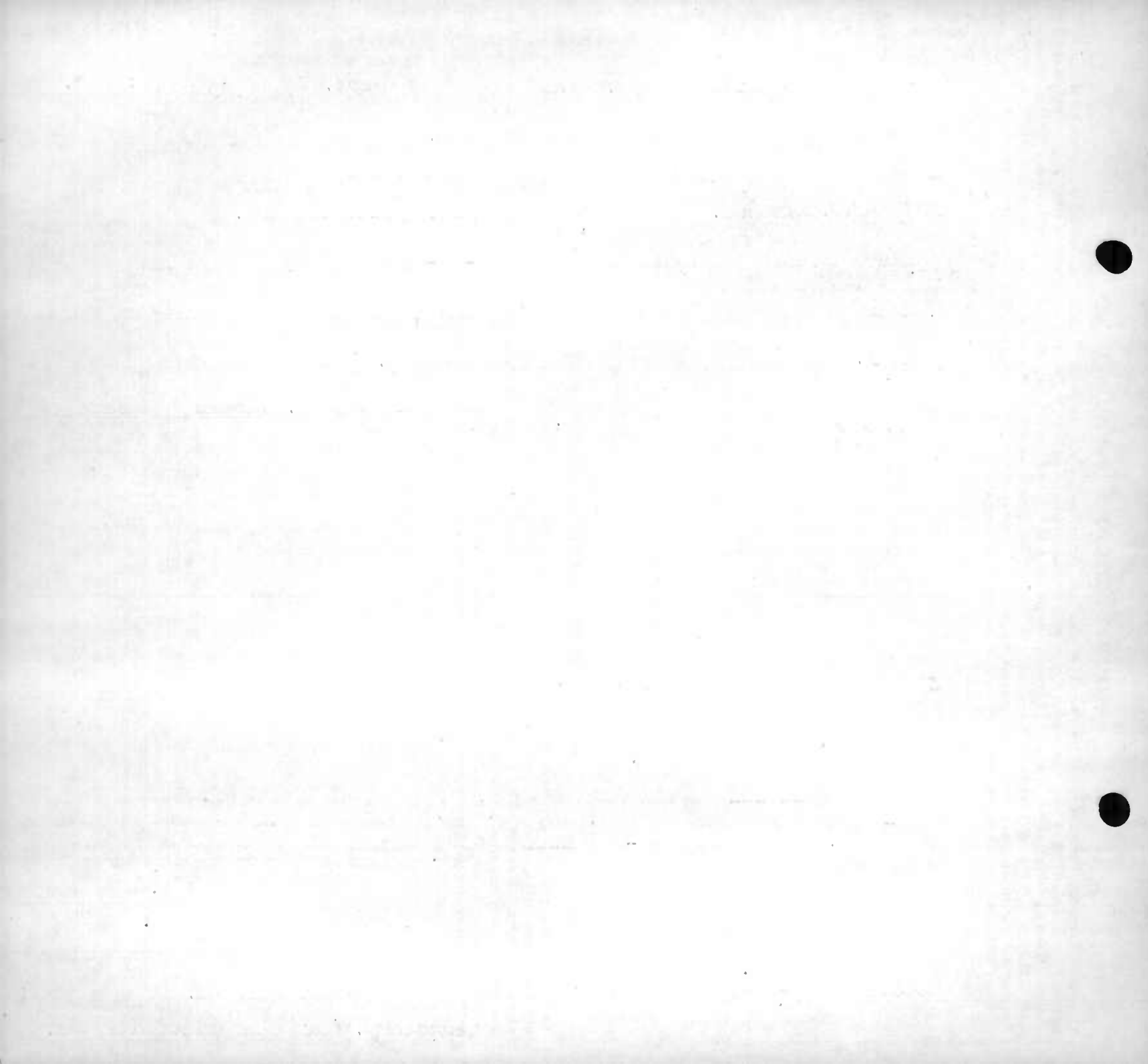
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 65 9643 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 9643 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Mr. Edward P. Durkin</i> | | 2. DATE AND HOUR OF DEATH <i>9-18-65</i> <i>8:23</i> a.m. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>Balt.</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balt.</i> #6 <i>63700</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i> | | (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location) <i>6113 Macdonald Ave</i> | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i> | B. DATE OF BIRTH <i>6-14-18</i> | 9. AGE (In years last birthday) <i>47</i> yrs | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>City Police</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Patrolman</i> | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>AMERICAN</i> | | 13. FATHER'S NAME <i>PATRICK DURKIN (D)</i> | | 14. MOTHER'S MAIDEN NAME <i>MARGARET BROWN (L)</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes</i> <i>WW 2</i> | | 16. SOCIAL SECURITY NO. <i>215-09-7957</i> | | 17. INFORMANT <i>Mrs. Gertrude Durkin</i> | |
| 18. <i>200.2</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <i>Pulmonary embolism</i> DUE TO (B) <i>Femoral phlebotrombosis</i> DUE TO (C) <i>Malignant Lymphoma</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>5 hr</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSE OF DEATH? <i>Yes</i> | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <i>9-18</i> 19 <i>65</i> to <i>9-18</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>9-18</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <i>Hudson Fesche</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>9-18-65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>P. HUDSON FESCHE</i> | | 23D. ADDRESS <i>Union Memorial Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>9/22/65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Parkwood Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 20 1965</i> | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i> | | 25C. FUNERAL DIRECTOR <i>L. J. Buck, Inc. Balto. 14 Md.</i> | | | |
| 25D. ADDRESS | | | | | |

P. HINDLE BECHTOLD

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

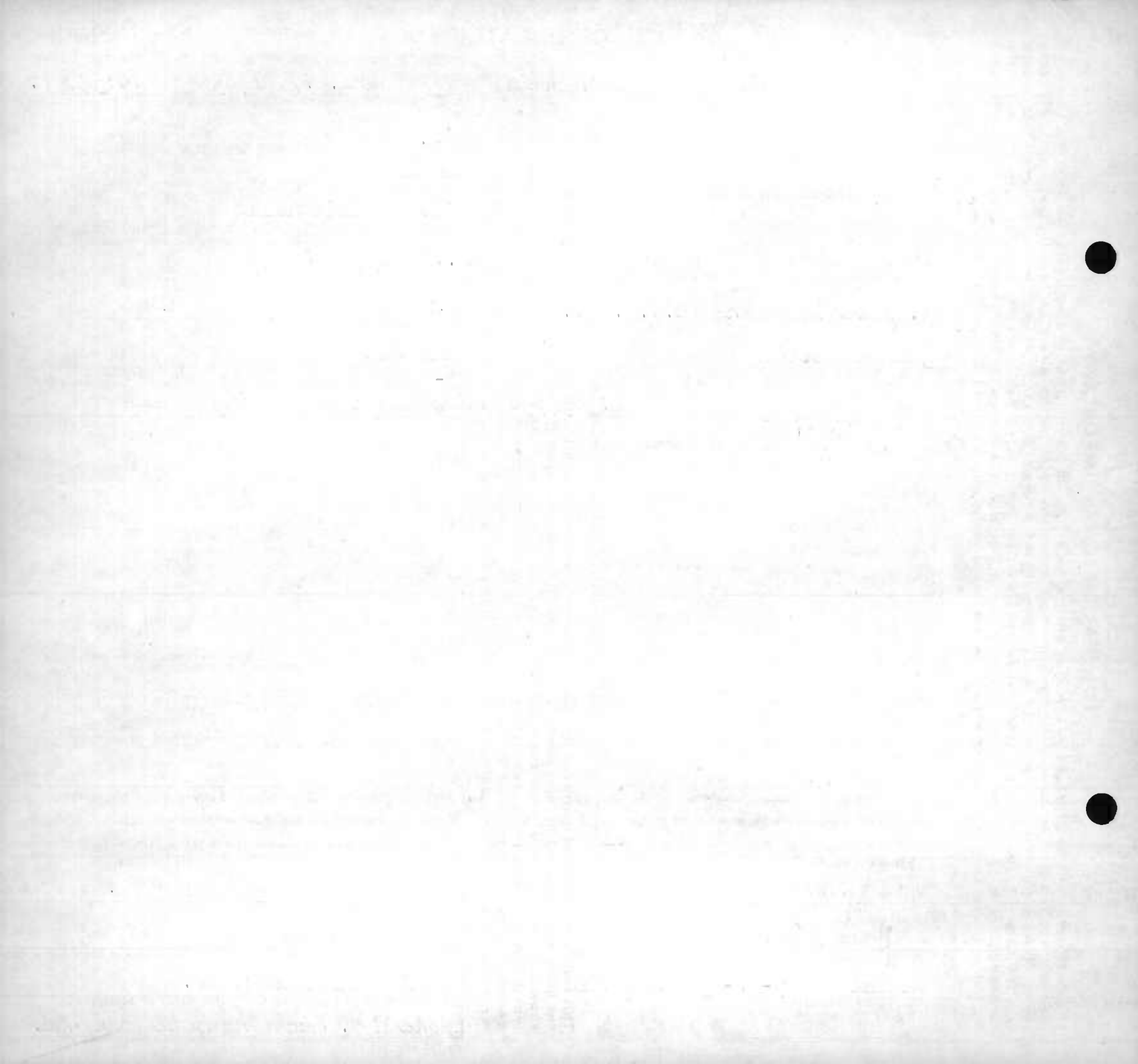
| BIRTH NO. 65 9644 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9644 | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|------------------------------------------------------------------------|-----------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Margaretta Thomas</i> | | | | 2. DATE AND HOUR OF DEATH <i>Sept. 19, 1965 5:30 A. M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>9-05</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>90 Ardleigh Nursing Home</i> <i>2095 Rockrose Ave.</i> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <i>3228 Ellerslie Ave.</i> | | | |
| 5. SEX <i>female</i> | 6. RACE <i>white</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>widowed</i> | 8. DATE OF BIRTH <i>8-28-1881</i> | 9. AGE (In years last birthday) <i>84</i> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | |
| 13. FATHER'S NAME <i>John F. Hopkins</i> | | | 14. MOTHER'S MAIDEN NAME <i>Mary E. Ernst</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Miss Margaret I. Thomas</i> | | |
| | | | | | ADDRESS <i>same</i> | | |
| 18. <i>260X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) <i>Arteriosclerotic cardio-vascular disease</i> DUE TO (B) <i>Diabetes mellitus</i> DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs.</i> <i>6 yrs.</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Dec. 6, 1964</i> to <i>Sept. 19, 1965</i> , that (I) (we) last saw the deceased alive on <i>Sept. 14, 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Lloyd E. Saylor</i> M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>Sept. 20, 1965</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Lloyd E. Saylor</i> | | | | 23D. ADDRESS M.D. <i>3902 Greenmount Avenue</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i> | | 24B. DATE <i>9-22-65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Oak Lawn Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 20 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Saylor</i> | | 25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc</i> | | ADDRESS <i>Baltimore, Md.</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

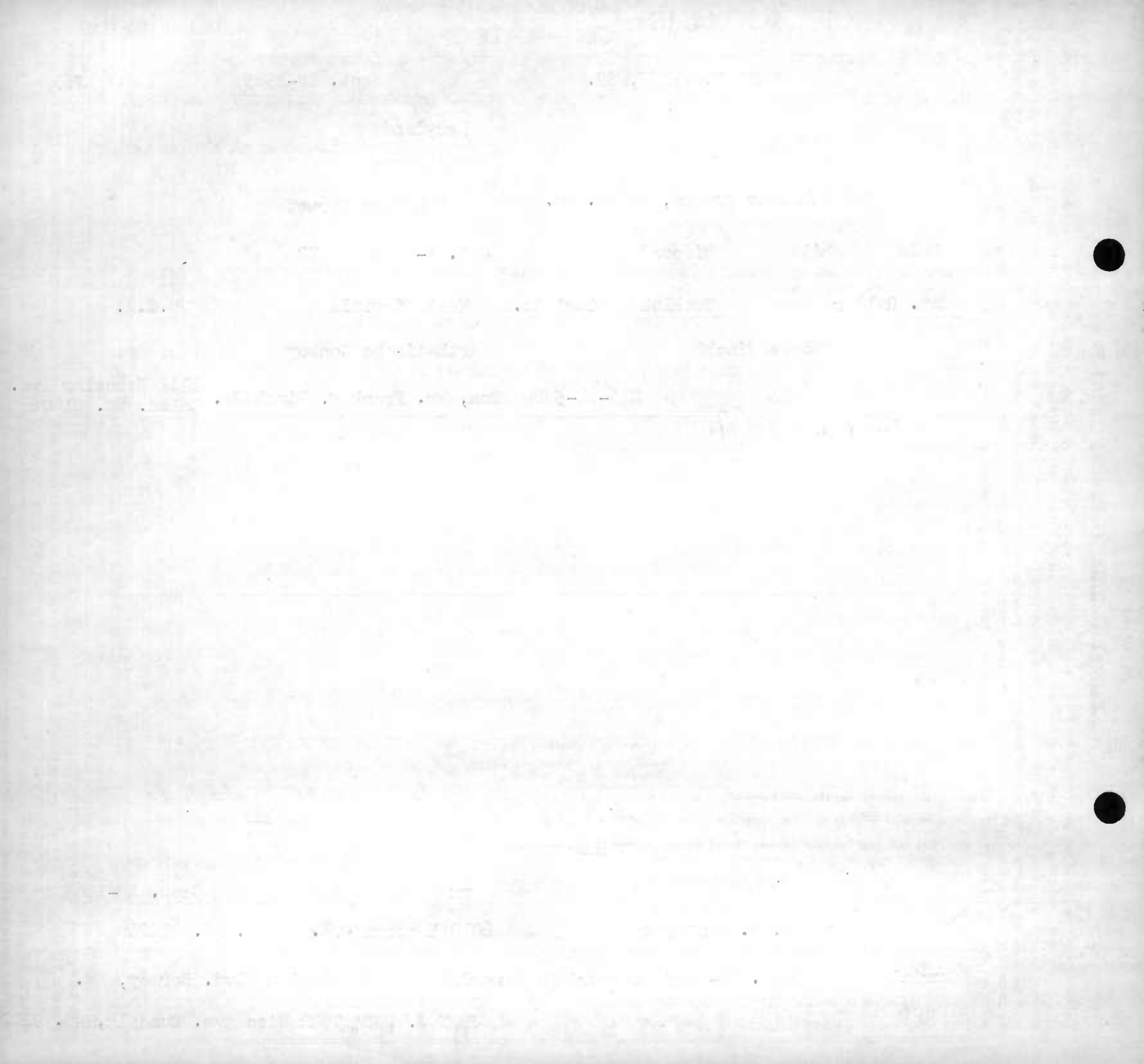
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9645 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|--------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. 65 9645 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Louis Mehling</i> | | 2. DATE AND HOUR OF DEATH <i>Sept. 17, 1965 10:53 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) | | A. STATE <i>Md.</i> B. COUNTY <i>8-01</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>2217 Belair Road</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | D. STREET ADDRESS (If rural, give location) <i>2217 Belair Road</i> | |
| 5. SEX <i>male</i> | 6. RACE <i>white</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>widowed</i> | 8. DATE OF BIRTH <i>Jan. 18, 1874</i> | 9. AGE (In years last birthday) <i>91</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Superintendent</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>B.T.C. Co.</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>George Mehling</i> | | 14. MOTHER'S MAIDEN NAME <i>Anna Puls</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>213059736</i> | | 17. INFORMANT <i>Miss Margaret Mehling</i> ADDRESS <i>same</i> | |
| 18. <i>332X41260X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | (A) <i>Embol Thrombosis</i> DUE TO | | <i>24 hr</i> | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <i>Atherosclerosis, generalized</i> DUE TO | | <i>5 yr</i> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <i>Diabetes Mellitus</i> | | <i>5 yr</i> | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>7:15 am</i> <i>19 54</i> to <i>17 September</i> <i>19 65</i> , that (I) (we) last saw the deceased alive on <i>16 Sept</i> <i>19 65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Howard Goodman</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>19 Sept. 65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>HOWARD GOODMAN</i> | | 23D. ADDRESS <i>3604 Harford Rd</i> | | <i>Baltimore (34) Md</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i> | | 24B. DATE <i>9-21-65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i> | |
| 24D. LOCATION (City, town, or county) <i>Baltimore, Md.</i> | | 24E. STATE <i>Md.</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 20 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Fickel</i> | | 25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc</i> | |
| 25D. ADDRESS <i>Baltimore, Md.</i> | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

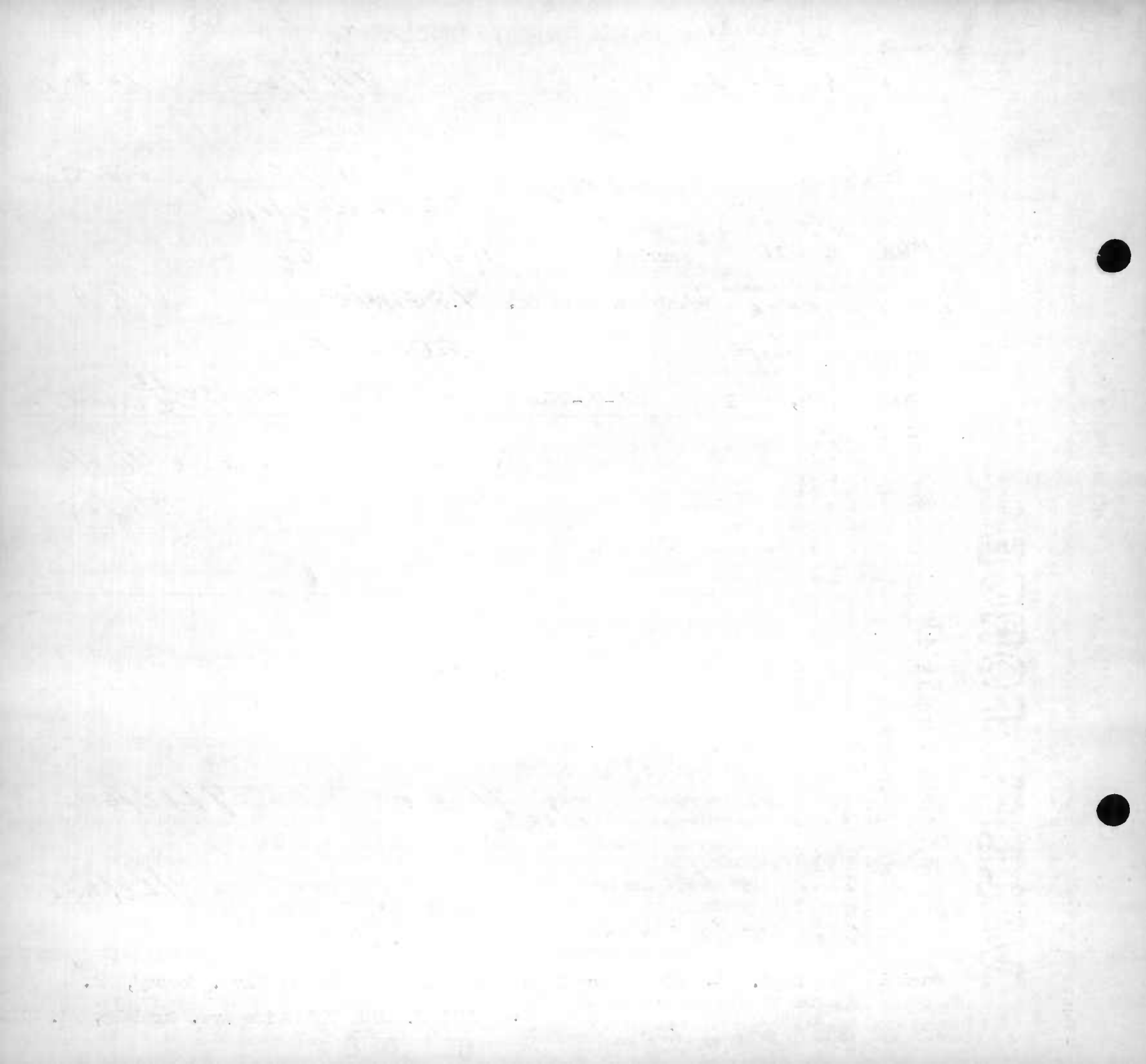
| BIRTH NO. | | 65 9646 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9646 | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------|---------------------------------------|-------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| FRANK F. FINCH, SR. | | | | Sept. 18-1965 8 ³⁰ am M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE Maryland | | | |
| | | | | B. COUNTY Baltimore | | | |
| 1311 Scheeler Avenue, Balto. Md. | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 507 Savage Street | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | | 8. DATE OF BIRTH Oct. 5-1887 | 9. AGE (In years lost birthday) 77 | 10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Roller | | 10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co. | | 11. BIRTHPLACE (State or foreign country) West Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Thomas Finch | | | | 14. MOTHER'S MAIDEN NAME Arthelia Mc Conkey | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 213-07-5888 | | 17. INFORMANT Son, Mr. Frank F. Finch Jr. | | | |
| | | | | ADDRESS 1311 Scheeler Ave. Balto. Md. 21206 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) Acute pulmonary edema DUE TO (B) Congestive heart failure DUE TO (C) Hepatic Cirrhosis | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 4 th 1965 to Sep. 18 1965, that (I) last saw the deceased alive on Sep. 16 1965 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE R. A. Santayana | | | | | | 23B. DATE SIGNED Sept. 20-1965 | |
| 23C. PHYSICIAN'S NAME (Type) R. A. Santayana | | | | 23D. ADDRESS 6010 Eastern Ave. Balto. Md. 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Sept. 21-1965 | | 24C. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial | | 24D. LOCATION (City, town, or county) (State) Washington Blvd. Dorsey, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 21 1965 | | 25B. NAME OF REGISTRAR Robert E. ... | | 25C. FUNERAL DIRECTOR JOHN J. DUDA | | ADDRESS 7922 Wise Ave. Dundalk, Md. 21224 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------|-------------------------------------------|
| BIRTH NO. 65 9647 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9647 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) John L. Little | | 2. DATE AND HOUR OF DEATH 9/18/65 10:25 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 36 FRANKLIN SQUARE Hosp. | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Balt C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21224 D. STREET ADDRESS (If rural, give location) 7202 Woodrow Ave. 53-00 | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 1/6/17 | 9. AGE (In years last birthday) 48 | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEEL WORKER | | 10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co. | | 11. BIRTH PLACE (State or foreign country) VIRGINIA | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME GEORGE LITTLE | | 14. MOTHER'S MAIDEN NAME FLORA FORD | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes Army, WW II | | 16. SOCIAL SECURITY NO. 227-09-7916 | | 17. INFORMANT ADDRESS CATHERINE LITTLE wife 7202 Woodrow Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cerebral Thrombosis | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 9/16/65 to 9/18/65 | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/16/65 19 to 9/18/65 19 that (I) (we) last saw the deceased alive on 9/18/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Silvino B. Munozes | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/18/65 | |
| 23C. PHYSICIAN'S NAME (Type) Silvino B. Munozes | | 23D. ADDRESS M.D. 101 Calhoun St. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Sept. 22-1965 | | 24C. NAME of CEMETERY or CREMATORY Meadowridge Memorial | |
| 24D. LOCATION Washington Blvd. Dorsey, Md. | | 24E. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 21 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR JOHN J. DUDA 7922 Wise Ave. Dundalk, Md. 21222 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 55 9648 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|---------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. | | CERTIFICATE OF DEATH | | 2. DATE AND HOUR OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Alice C Hammond | | 9-19-65 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY | | M. STATE | |
| 1810 W North ave | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | 15-04 | |
| | | D. STREET ADDRESS (If rural, give location) | | 1810 W North ave | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| Female | Colored | Single | Feb 16-1892 | 72 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | Florist | | Balt Md | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| James E Hammond | | Annie Johnson | | U.S.A | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | 216-32432 | | Ethel Jackson 1810 W North ave | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 159 X I | | (A) METASTATIC CARCINOMA | | | |
| ANTECEDENT CAUSES | | (B) CARCINOMA OF THE GASTROINTESTINAL TRACT (SITE UNDETERMINED) | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | 23B. DATE SIGNED | | |
| John S. Braxton | | | | 9/20/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| JOHN S. BRAXTON | | 922 S. Sharp Balt 39 Md | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) | 24B. DATE | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| | SEP 22 1965 | Mt. Auburn | | Balt. Md | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| SEP 21 1965 | Robert E. Jackson | (Mrs) Frances A. Newsley | | 676 W. Middle St. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9649 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9649 | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|--------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|----------------------------------------------------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| | | | | Mrs. EDNA P. WEER | | 9-20-65 12:14 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| 35 Church Home Hospital | | | | Maryland 27-11 | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | | | Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | 4544 N. Charles St. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| F | W | married | 2-10-93 | 72 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| H. wife | | | | Maryland | | USA | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| William H. Bonwill | | | | Mary Miller | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| | | 215-03-10215 | | Chart | | | |
| 18. 433.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | (A) DUE TO | | myocardial | |
| | | | | (B) DUE TO | | myocardial | |
| | | | | (C) DUE TO | | myocardial | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 0 | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-14 1965 to 9-20 1965, that (I) (we) last saw the deceased alive on 9-20 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| A. E. SUBONG, JR. | | | | Church Home Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Entombment | | 9/22/65 | | Lorraine Mausoleum | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| SEP 21 1965 | | Robert E. Taylor | | Harry H. Armas | | 4204 Ridgely Road Balto. Md. 21215 | |

WALTER A. BOWEN

Church from 1875

F. W. Bowen

William F. Bowen

2-10-13 72

Marjorie

Mary Miller

Chart

Golden Knot

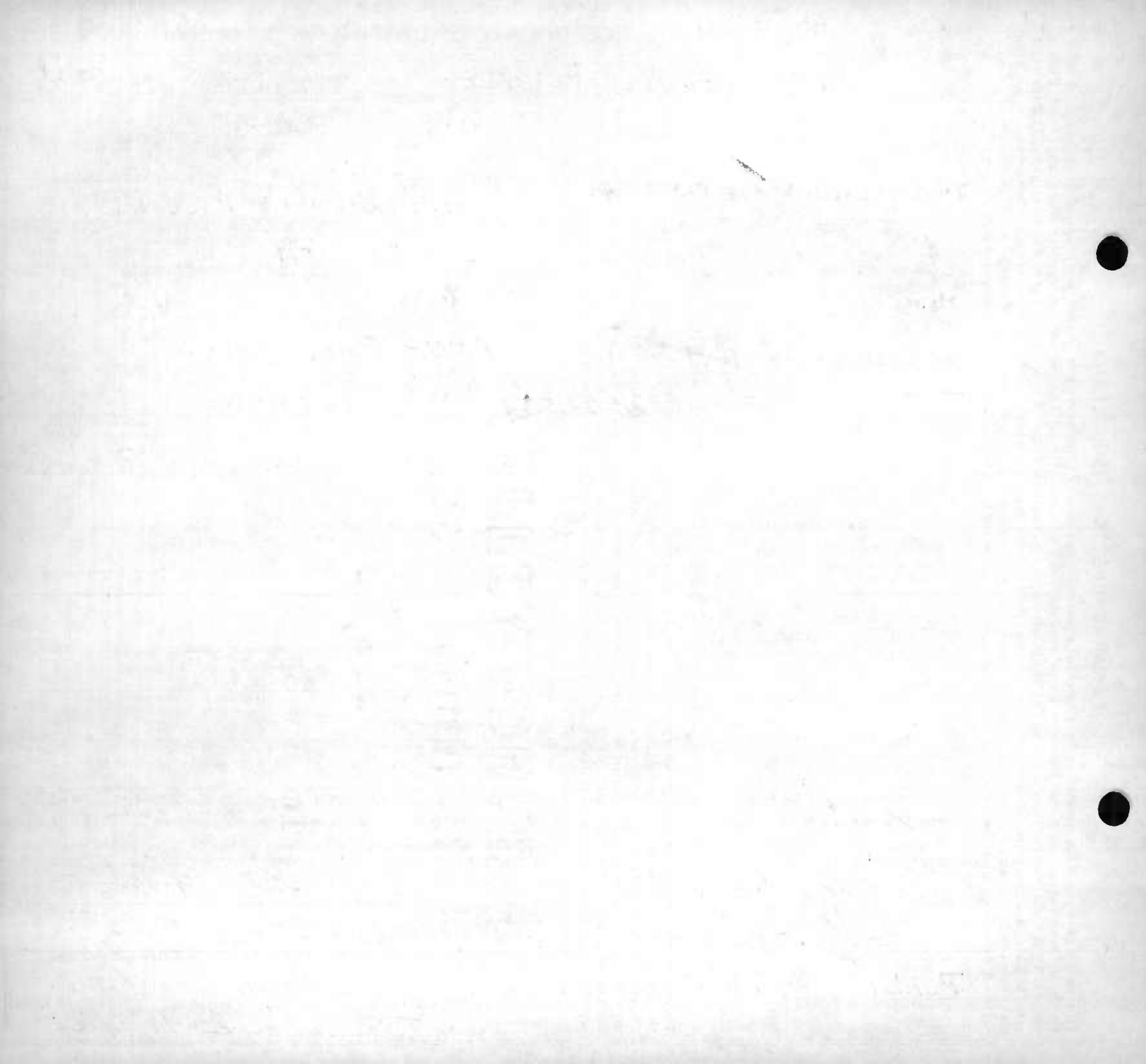
James A. Bowen
Barnes & Bowen

A. E. Bowen
Church from 1875

FUNERAL DIRECTOR: IMPORTANT

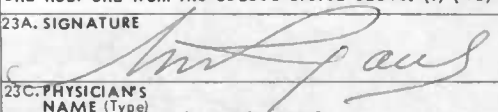
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

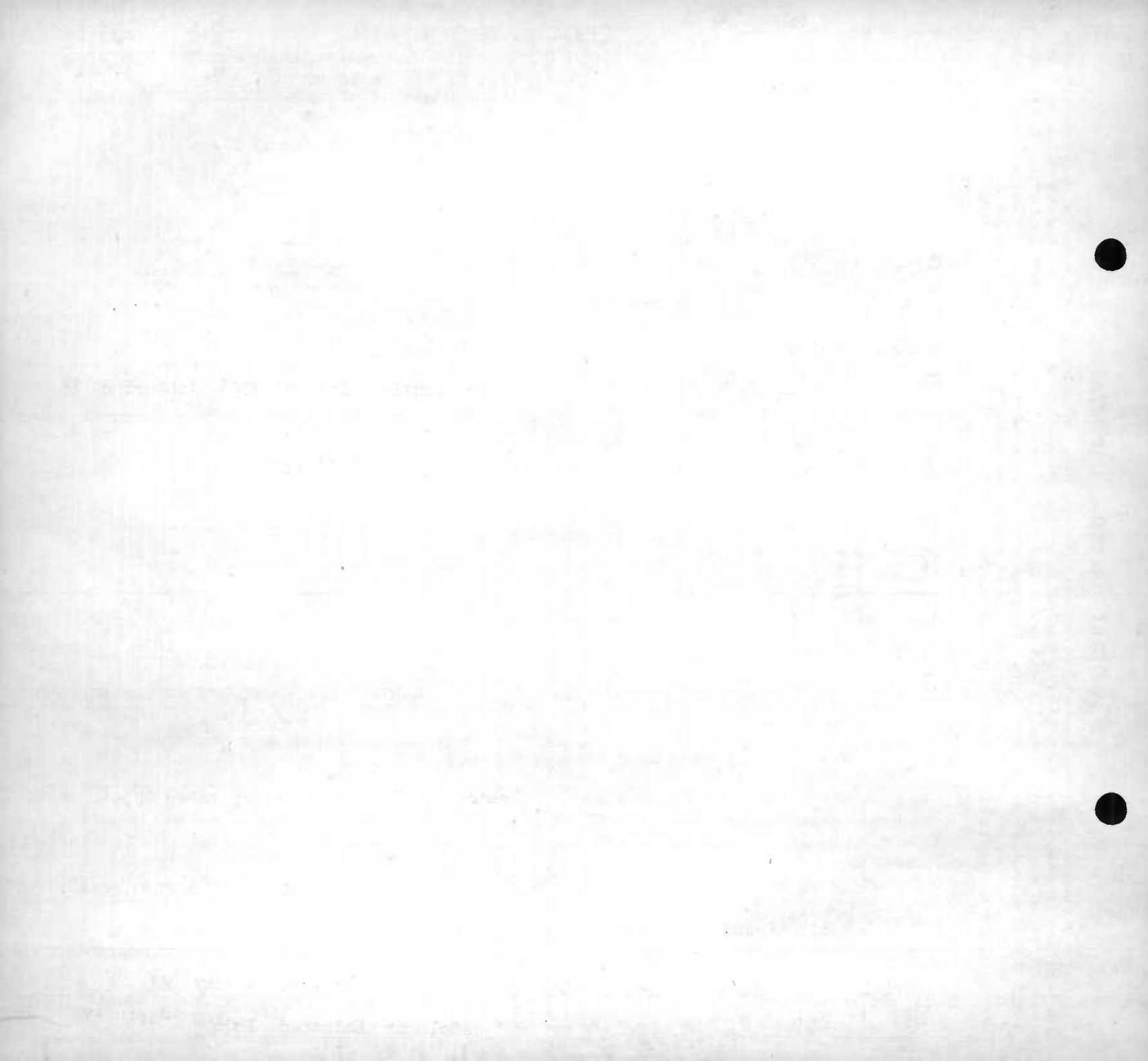
| | | | | | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|----------------------------------------------------|-----------------------------------------------------------|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | 65 9650 | | BIRTH NO. | | 65 9650 | | CERTIFICATE OF DEATH | | Registered No. 65 9650 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) MARY ELEANOR FOWBLE | | | | | | 2. DATE AND HOUR OF DEATH 9-18-65 9:27 P.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE-MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MONTEBELLO STATE HOSPITAL | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE MD. B. COUNTY BALTO. C. CITY OR TOWN (If outside city limits, write RURAL and give township) WOODLAWN 53-00 D. STREET ADDRESS (If rural, give location) 6414 WINDSOR MILL RD. | | | | | |
| 5. SEX F | | 6. RACE W | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | | 8. DATE OF BIRTH 12-17-93 | | 9. AGE (In years last birthday) 71 | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MD | | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | |
| 13. FATHER'S NAME WASHINGTON HIRSCH | | | | | | 14. MOTHER'S MAIDEN NAME ANNA BOCKLEMAN | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. 217.34.5374 | | 17. INFORMANT HOSP. RECORD | | | ADDRESS | | |
| 18. 172X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ADENOCARCINOMA OF ENDOMETRIUM ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | | INTERVAL BETWEEN ONSET AND DEATH 3 YEARS | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8-3 1965 to 9-18 1965 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 9-18 1965 and that <input checked="" type="checkbox"/> (our) opinion of death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Irving L. Cooperstein M.D. | | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED 9-18-65 | | |
| 23C. PHYSICIAN'S NAME (Type) Irving L. Cooperstein | | | | | | 23D. ADDRESS M.D. MONTEBELLO STATE HOSP. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Sept. 21/65 | | 24C. NAME of CEMETERY or CREMATORY Lorraine | | 24D. LOCATION (City, town, or county) (State) Woodlawn md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 21 1965 | | 25B. NAME OF REGISTRAR Robert E. F... | | 25C. FUNERAL DIRECTOR John T. Stansbury | | ADDRESS 6411 Windsor Mill Rd. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

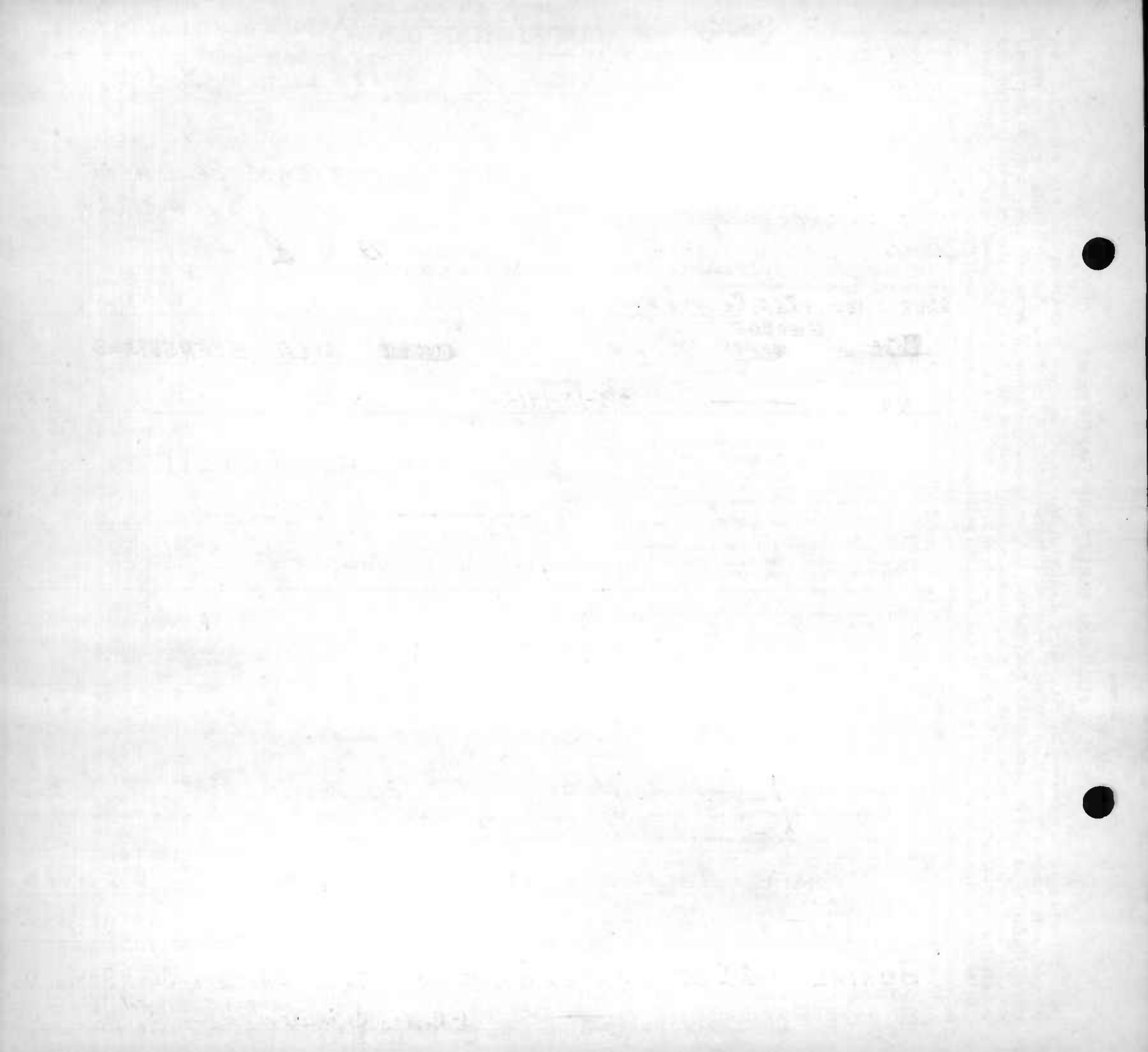
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9651 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 65 9651 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Brooks, John | | | 2. DATE AND HOUR OF DEATH September 18, 1965 2:45 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 11-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 723 North Eutaw Street | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH Unknown | 9. AGE (In years last birthday) 93 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook | | 10B. KIND OF BUSINESS OR INDUSTRY Restaurant | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME Thomas Brooks | | |
| 14. MOTHER'S MAIDEN NAME Maggie | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT Mr Jonsie Brooks ADDRESS 2106 Ashburton St | | |
| 18. 434.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Congestive Heart Failure DUE TO (B) _____ DUE TO (C) Arteriosclerosis. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from September 13, 1965 to September 18, 1965 , that (I) (we) lost saw the deceased alive on September 18, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE  M.D. Marie Rigaud | | | | 23B. DATE SIGNED September 18, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Marie Rigaud | | | | 23D. ADDRESS M.D. 1514 Division Street | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9/22/65 | 24C. NAME OF CEMETERY or CREMATORY Brooks Chapel | | 24D. LOCATION (City, town, or county) (State) Calvert County Md | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 21 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Adolphus Halstead 1206 W North Ave | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9652 | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|
| BIRTH NO. 65 9652 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) CHARLES EDWARD BEALL | | | | 9-18-65 @ 8:55 AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE md. B. COUNTY 26-89 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) HOSP. FOR THE WOMEN OF MD. | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) HIGH LAND TOWN - BALTIMORE | |
| | | | | D. STREET ADDRESS (If rural, give location) 3925 FOSTER AVE. #21224 | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 1-24-93 | 9. AGE (In years last birthday) 72 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AMER. SMELT. & REF. CO. RETIRED | | | 11. BIRTHPLACE (State or foreign country) Prince Geo. Co. Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME GEORGE BEALL | | | 14. MOTHER'S MAIDEN NAME ELLA EVERSFIELD | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 212-10-1412 | | 17. INFORMANT ADDRESS GENEVIEVE Raymond 8417 Hallmark Ct. |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac arrest | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19A. DATE OF OPERATION 4-20-61 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED myocardial infarction | | |
| 19C. DATE OF OPERATION Tracheotomy | | | 19D. CONDITION FOR WHICH OPERATION WAS PERFORMED resp. arrest | | |
| 20A. AUTOPSY? (Yes or No) NO | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | |
| 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept. 17 1965 to Sept. 18 1965 , that (I) (we) last saw the deceased alive on Sept. 18 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Pacita D. Tan M.D. | | | | 23B. DATE SIGNED Sept. 18, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) PACITA D. TAN M.D. | | | | 23D. ADDRESS Hosp. for Women of Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-22-65 | | 24C. NAME OF CEMETERY or CREMATORY OAK LAWN CEM. | |
| 24D. LOCATION (City, town, county) (State) 7225 EASTERN BLVD. BA. CO. MD. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 21 1965 | | | |
| 25B. NAME OF REGISTRAR P. B. E. F. J. J. | | 25C. FUNERAL DIRECTOR ADDRESS Charles J. Jailer BALTO., MD. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|----------------------------------------------------------------|
| BIRTH NO. 65 9653 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9653 | |
| 1. NAME OF DECEASED (Type or Print) Winfield Robinson | | | 2. DATE AND HOUR OF DEATH 9/17/65 1130 P. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hosp. Baltimore Md. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY HARFORD C. CITY OR TOWN (If outside city limits, write RURAL and give township) White Hall 21161 62-00 D. STREET ADDRESS (If rural, give location) TROYER ROAD | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 8/16/94 | 9. AGE (In years last birthday) 71 | If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life when if retired) RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY GEN FARMING | | 11. BIRTHPLACE (State or foreign country) Maryland FALLSTON | |
| 13. FATHER'S NAME CHARLES EVANS ROBINSON | | | 14. MOTHER'S MAIDEN NAME Albertha Coe | | |
| 15. Was Deceased Ever in U.S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW I 212-32-4676 | | | 16. SOCIAL SECURITY NO. 212-32-4676 | | |
| 17. INFORMANT EMMA JANE ROBINSON | | | ADDRESS WHITE HALL MARYLAND | | |
| 18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASHD, = acute coronary occlusion | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/12 19 65 to 9/17 19 65 and that (I) (we) last saw the deceased alive on 9/17 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Dr. Stephen Margolis M.D. | | | | 23B. DATE SIGNED 9/17/65 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Stephen Margolis | | | | 23D. ADDRESS Md. General Hosp | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/21/1965 | | 24C. NAME OF CEMETERY or CREMATORY ST. PAUL | |
| 24D. LOCATION (City, town, or county) (State) RYLESVILLE MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT. SEP 21 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. ... | | 25C. FUNERAL DIRECTOR ADDRESS Charles E. Runtz Jarrettsville Md. | | | |

University of Wisconsin

Madison, Wisconsin

March 11, 1914

Dear Mr. Cole

Albany, N.Y.

My dear Mr. Cole

ACAD

Very truly yours

Wm. C. Cresswell

B-320

| BALTIMORE CITY HEALTH DEPARTMENT | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | Registered No. 9654 | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------|--|
| BIRTH NO. 65 9654 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) GEORGE BATZ | | 2. DATE AND HOUR PRONOUNCED DEAD September 16, 1965 1:55 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1123 Reisterstown Road | | | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married | 8. DATE OF BIRTH Feb-23-1904 | 9. AGE (In years last birthday) 61 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician | | 10B. KIND OF BUSINESS OR INDUSTRY Property Co. Co. | | 11. BIRTHPLACE (State or foreign country) Balto Co. Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Edward Batz | | 14. MOTHER'S MAIDEN NAME Loretta Eger | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) no | | | |
| 16. SOCIAL SECURITY NO. 718094945 | | 17. INFORMANT Raymond A. Batz, Jr. | | | | | |
| 18. CAUSE OF DEATH 422.1 | | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (A) DUE TO | | | (B) DUE TO | | |
| 19A. DATE OF OPERATION 22 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breitenecker, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED September 17, 1965 | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE Sep 20-65 | 23C. NAME OF CEMETERY or CREMATORY Greenwood | | 23D. LOCATION (City, town, or county) (State) Frederick, Md. | | |
| 24A. DATE REC'D BY HEALTH DEPT. SEP 21 1965 | | 24B. NAME OF REGISTRAR Robert E. Fairbank | | 24C. FUNERAL DIRECTOR Frank H. Hartzell, Pikesville | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------|--|----------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------|--|---------------------------------------------------------------|--|
| Certificate of Death | | | | | | | | | | | |
| Registered No. 65 9655 | | | | | | | | | | | |
| BIRTH NO. 65 9655 | | | | | | | | | | | |
| M.E. CASE NO. | | | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) LAWRENCE G. KNIGHT | | | | | | 2. DATE AND HOUR OF DEATH 9-17-65 7:20 P.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hosp | | | | | | A. STATE Maryland B. COUNTY Baltimore | | | | | |
| | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | | | |
| | | | | | | D. STREET ADDRESS (If rural, give location) 308 Cedar Drive #20 | | | | | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married | | 8. DATE OF BIRTH 8-10-11 | | 9. AGE (In years last birthday) 54 | | 10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Estimator | | | | 10B. KIND OF BUSINESS OR INDUSTRY Martin Co. | | | | 11. BIRTHPLACE (State or foreign country) Maryland | | | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME LAWRENCE KNIGHT SR. | | | | 14. MOTHER'S MAIDEN NAME LONA PHILLIPS | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 215-03-9432 | | | | 17. INFORMANT Mrs Stella J Knight | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 592X I | | | | CAUSE OF DEATH (A) chronic glomerulo-nephritis (B) (C) INTERVAL BETWEEN ONSET AND DEATH years | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-19-65 19 to 9-17 19 65 , that (I) we last saw the deceased alive on 9-17 19 65 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE Jose S. Marios | | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-17-65 | | | |
| 23C. PHYSICIAN'S NAME (Type) Jose S. Marios | | | | | | 23D. ADDRESS Church Home & Hospital | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/21/65 | | 24C. NAME of CEMETERY or CREMATORY Morland Memorial Pk | | | | 24D. LOCATION (City, town, or county) (State) Balto. Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 21 1965 | | | | 25B. NAME OF REGISTRAR Robert E. Taylor | | | | 25C. FUNERAL DIRECTOR John Byers | | | |
| | | | | ADDRESS 8728 Liberty Rd. Randalltown | | | | | | | |

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65 9656

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. *New Jersey* MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. *65 9656*

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) COLIN N. WEBSTER

2. DATE AND HOUR PRONOUNCED DEAD September 19, 1965 4:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY *Baltimore*

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 221 Gateswood Road

5. SEX Male

6. RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH 7/3/1960

9. AGE (In years last birthday) 5

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none

11. BIRTHPLACE (State or foreign country) New Jersey

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME George H. Webster

14. MOTHER'S MAIDEN NAME Audrey Foster

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO. none

17. INFORMANT ADDRESS Family records

18. CAUSE OF DEATH

(A) Drowning

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) Swimming pool

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 222 Gateswood Road

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute) 9 19 65 3:20 P.M.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Found submerged in swimming pool

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☒

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☐

ACTUAL SIGNATURE *Russell S. Fisher* M.D.

EXAMINER'S NAME (Type) Russell S. Fisher, M.D.

DATE SIGNED 9-20-65

23A. BURIAL CREMATION, REMOVAL (Specify) Burial

23B. DATE 9/20/65

23C. NAME OF CEMETERY or CREMATORY Dulaney Valley Memorial

23D. LOCATION (City, town, or county) (State) Cockeysville, Md.

24A. DATE REC'D BY HEALTH DEPT. SEP 21 1965

24B. NAME OF REGISTRAR *Robert S. Fisher*

24C. FUNERAL DIRECTOR John Burns Sons

24D. ADDRESS Towson

VS 151-REV. 1/1/65

N 990X

WILSON

| NAME | ADDRESS | CITY | STATE |
|-------------------|---------|------|-------|
| George H. Webster | 1000 | 1000 | 1000 |
| James Foster | 1000 | 1000 | 1000 |
| Emily Foster | 1000 | 1000 | 1000 |

Wilson, Anthony Valley, Pennsylvania, 1000

John Foster, 1000

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 9657 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 9657

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CHARLOTTE L. GRANT

2. DATE AND HOUR PRONOUNCED DEAD

9/9/65 3:10 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1113 McKean Ave.

5. SEX

female

6. RACE

colored

7. ~~MARRIED~~ NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

Jan 7-1931

9. AGE (In years
last birthday)

34

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

DOMESTIC

11. BIRTHPLACE (State or foreign country)

LA PLATA, Md

12. CITIZEN OF
WHAT COUNTRY

U.S.A

13. FATHER'S NAME

MATTHEW WINTERS

14. MOTHER'S MAIDEN NAME

MARY KOSTIN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

SARAH ELIZABETH WINTERS

18. 678161

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)Respiratory failure
(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.Massive pulmonary atelectasis during delivery
(B) DUE TO

(C).....

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/10/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-14-65

23C. NAME OF CEMETERY or CREMATORY

SACRED HEART CEM.

23D. LOCATION

(City, town, or county)

(State)

LA PLATA MD

24A. DATE REC'D BY HEALTH DEPT.

SEP 21 1965

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

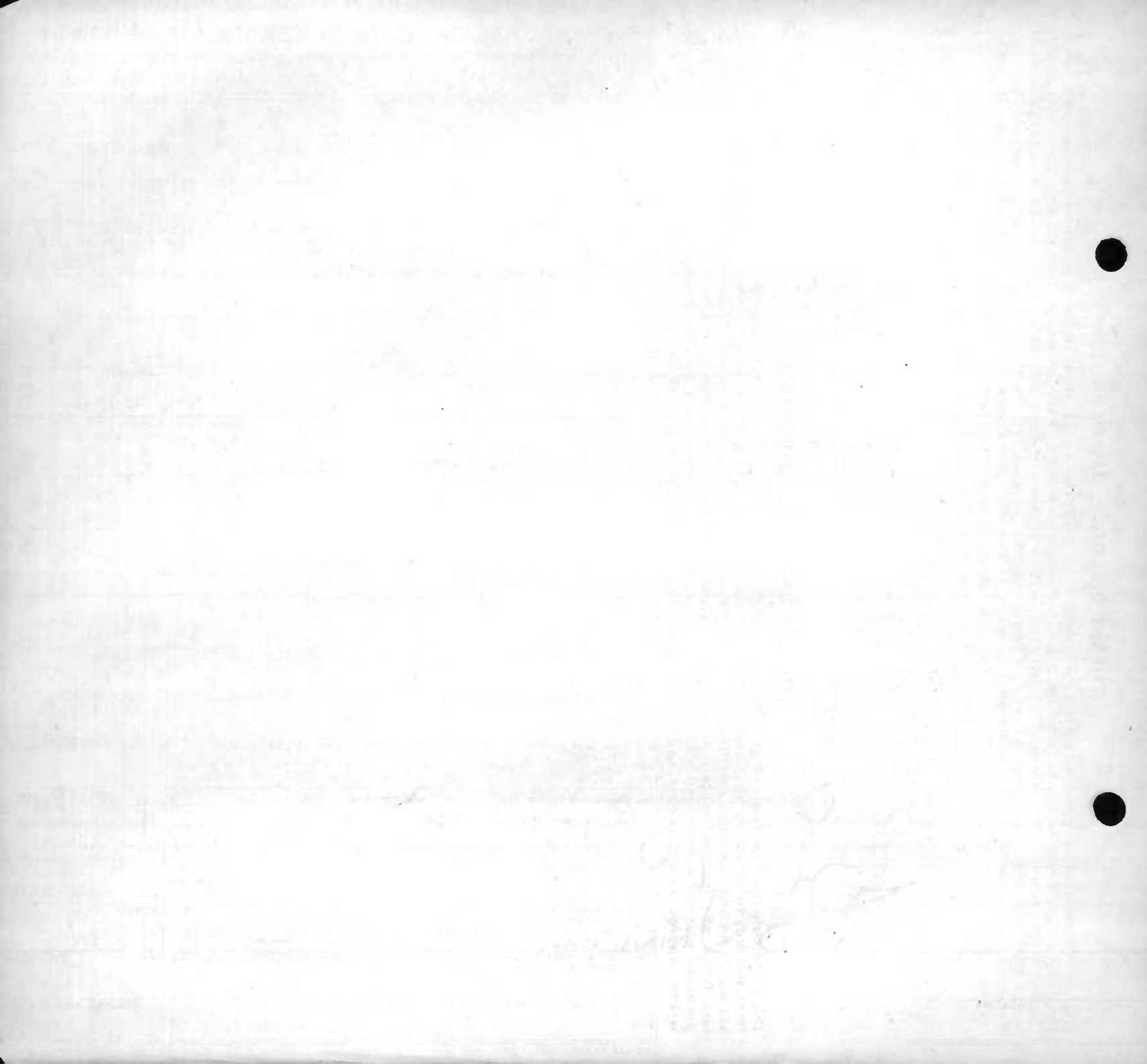
HUNTER FUNERAL HOME, WILKESBORO, MD

WALLLEY FOLIO
THE CONTENT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9658 | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--------------------------------------------------------------------------------------------|--|--|--|
| BIRTH NO. 65 9658 | | | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) John BERRY Sullivan | | | | Sept. 18 1965 11:55 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| 401 Guyton Ave. | | | | Maryland 20-07 | | | |
| 5. SEX | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| male | | | | Baltimore | | | |
| 6. RACE | | | | D. STREET ADDRESS (If rural, give location) | | | |
| Negro | | | | 401 Guyton Ave. | | | |
| 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | | | 8. DATE OF BIRTH | | | |
| married | | | | Nov 2, 1903 | | | |
| 9. AGE (In years last birthday) | | | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | |
| 61 | | | | Bethlehem Steel Co. | | | |
| 11. BIRTHPLACE (State or foreign country) | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| Lawrence S.C. | | | | S.C. | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Sam Sullivan | | | | Maggie Garlington | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| no | | | | 17. INFORMANT ADDRESS | | | |
| | | | | Frances Sullivan 401 Guyton Ave. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| 153.81 | | | | Carcinoma colon | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| July 21/65 | | | | Carcinoma | | | |
| 20A. AUTOPSY? (Yes or No) | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| no | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED | | | |
| | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (his hospital) attended the deceased from July 21 1965 to Sept 18 1965, that (I) (we) last saw the deceased alive on Sept 18 1965 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| [Signature] | | | | Sept 18-65 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| C. D. KINGTON M.D. | | | | 548 Hanlon Ave. Bal 21281 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | | |
| Burial | | | | 9/22/65 | | | |
| 24C. NAME of CEMETERY or CREMATORY | | | | 24D. LOCATION (City, town, or county) (State) | | | |
| Arlington Mem. Pk. | | | | Arlington Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | | |
| SEP 21 1965 | | | | Robert E. Taylor, M.D. | | | |
| 25C. FUNERAL DIRECTOR | | | | 25D. ADDRESS | | | |
| Earl Gilmore | | | | 1827 W. North Ave | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. 65 9659 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 9659 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Gee, Cardell L. | | | 2. DATE AND HOUR OF DEATH Sept. 19, 1965 8:20 A. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 8-06 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #13 D. STREET ADDRESS (If rural, give location) 1619 Rutland Ave. | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 11-24-1916 | 9. AGE (In years last birthday) 48 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | | 11. BIRTHPLACE (State or foreign country) N. Carolina | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Unknown | | | 14. MOTHER'S MAIDEN NAME Unknown | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS Anrair Gee-1619 Rutland Ave. | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 331X I Cerebral hemorrhage DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 9/21/65 INTERVAL BETWEEN ONSET AND DEATH NOT A MEDICAL EXAMINER'S CASE CHIEF OF ASST. MEDICAL EXAMINER | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept. 18, 19 65 to Sept. 19, 19 65 , that (I) (we) last saw the deceased alive on Sept. 19, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Jose D. Manalo M.D. | | | | 23B. DATE SIGNED Sept. 19, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Jose D. Manalo | | | 23D. ADDRESS M.D. 1400 N. Caroline St., 21213 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9-23-65 | 24C. NAME OF CEMETERY or CREMATORY Baltimore National | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 21 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR 1735 Harford Ave Marshall W. Jones, Jr. | |



1
D-253

65 9660

BALTIMORE CITY HEALTH DEPARTMENT

65 9660

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (KAZIHERAS)

CHARLES A. DAUKANTAS

2. DATE AND HOUR PRONOUNCED DEAD

September 19, 1965 2:10 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

740 ~~Ridgewood~~ Avenue RICHWOOD AVE

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

2/8/1917

9. AGE (In years last birthday)

48

If Under 1 Yr. If Under 24 Hrs. Months, Days, Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Mechanic

10B. KIND OF BUSINESS OR INDUSTRY

Bendy

11. BIRTHPLACE (State or foreign country)

Ind.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Alexander C. Daukantas

14. MOTHER'S MAIDEN NAME

Anna Idzelska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

W.W.II

16. SOCIAL SECURITY NO.

215-09-9663

17. INFORMANT

Mr. Anna Daukantas - 740 Richwood Ave.

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular

DUE TO disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9-20-65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

9/22/65

23C. NAME OF CEMETERY or CREMATORY

Holy Redeemer Cem.

23D. LOCATION (City, town, or county) (State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 21 1965

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

John J. Cowan & Son, Inc. 901 Hollins St

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>65 9661</u> | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. <u>65 9661</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Hess Marie L.</u> | | 2. DATE AND HOUR OF DEATH <u>9⁰⁵ AM 9-19-65</u> <u>9⁰⁵ AM</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSP OF BALTO, INC.</u> | | A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> <u>24-04</u> | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>1538 Riverside Ave #30</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>married</u> | 8. DATE OF BIRTH <u>5-11-02</u> | 9. AGE (in years last birthday) <u>63</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> | 11. BIRTHPLACE (State or foreign country) <u>Balto, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>Albert George</u> | | | 14. MOTHER'S MAIDEN NAME <u>Mary Neubert</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. | 17. INFORMANT <u>Harry M. Waleen, MD</u> ADDRESS <u>5356 Carriage Ct Balto. 29 Md.</u> | | |
| 18. <u>180X I</u> | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) <u>Cardiac standstill</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>?</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <u>metastatic renal cell carcinoma 13 years</u> | | | |
| | | (C) | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>8-12-1965</u> to <u>9-19-1965</u> , that (I) (we) last saw the deceased alive on <u>9-18-1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Harry M. Waleen</u> M.D. | | | | 23B. DATE SIGNED <u>9-19-65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Harry M. WALEEN</u> | | 23D. ADDRESS M.D. <u>5356 Carriage Ct. Balto. Md 21229</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>9 23 65</u> | 24C. NAME of CEMETERY or CREMATORY <u>Cedar Hill</u> | | 24D. LOCATION (City, town, or county) (State) <u>Brooklyn, A. A. Co. Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 21 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Jackson</u> | | 25C. FUNERAL DIRECTOR <u>Mc Gully</u> ADDRESS <u>130 E. Fort ve.</u> | |

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65 9662

BALTIMORE CITY HEALTH DEPARTMENT

65 9662

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

1. NAME OF DECEASED
(Type or Print)

WILLIAM O. CHANDLER

2. DATE AND HOUR PRONOUNCED DEAD

September 17, 1965 8:10 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

South Baltimore General Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

33 Montgomery St. (East)

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

10/17/24

9. AGE (In years
last birthday)

40

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Clerical

10B. KIND OF BUSINESS OR INDUSTRY

Aircraft

11. BIRTHPLACE (State or foreign country)

W. Virginia

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Fay P. Chandler

14. MOTHER'S MAIDEN NAME

Margaret K. Lawrence

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II

16. SOCIAL
SECURITY NO.

236 22 1582

17. INFORMANT

ADDRESS

Mrs. Betty Mitchell Reisterstown, Md

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A) Arteriosclerotic cardiovascular disease
DUE TO(B) _____
DUE TO

(C) _____

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Sept. 17, 1965

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/21/65

23C. NAME of CEMETERY or CREMATORY

Monte Vista Park Cem. Bluefield, W. Va.

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

SEP 21 1965

24B. NAME OF REGISTRAR

Robert E. Falek, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

JOHN F. DENNY, INC. 715 Light St.

WALTER & BROS.

Burial

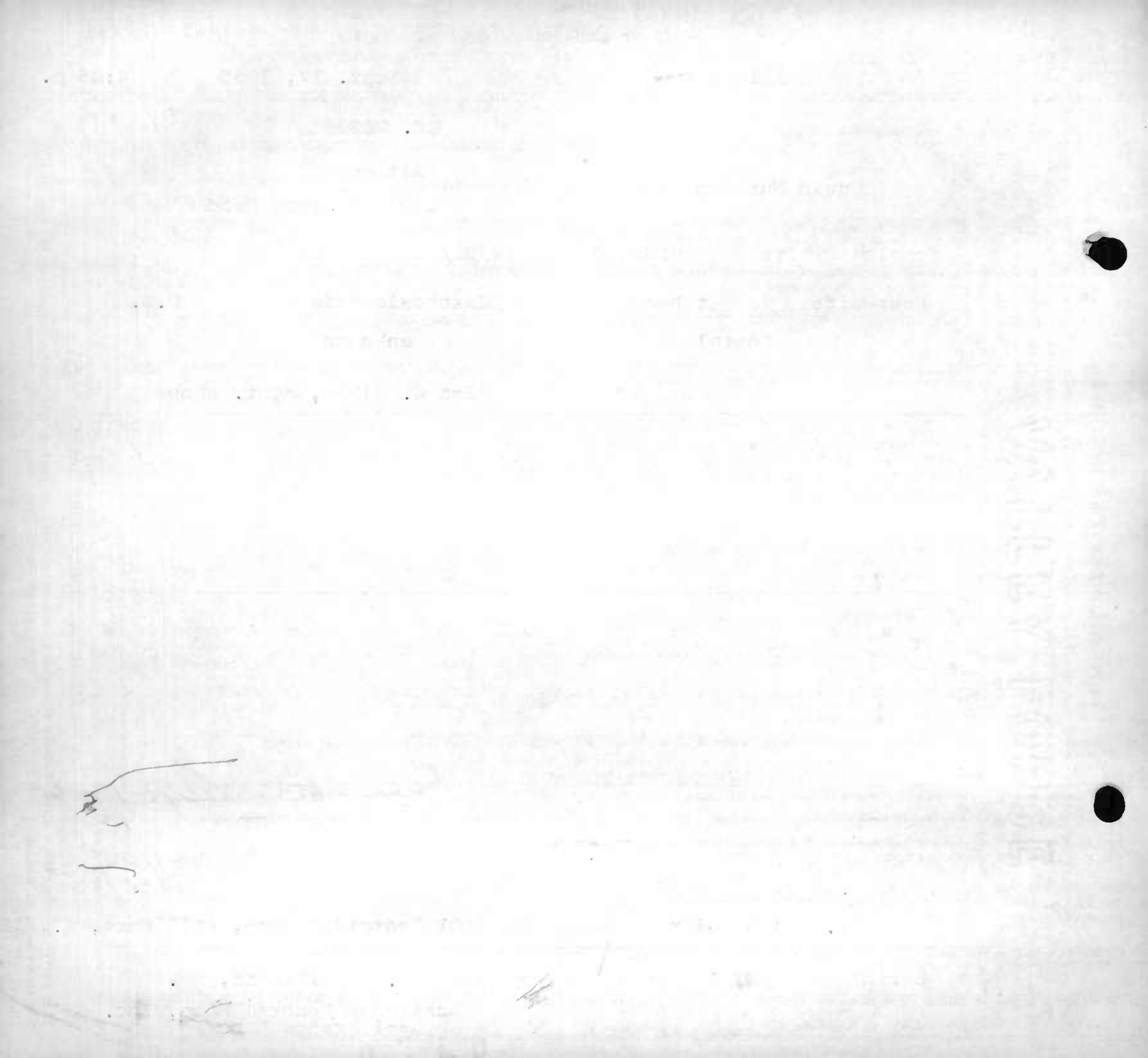
John V. ...

...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------|
| 65 9663 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9663 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | 2. DATE AND HOUR OF DEATH | |
| M.E. CASE NO. | | | | Sept. 17, 1965 4:45 p. M. | |
| 1. NAME OF DECEASED (Type or Print) | | EMILIE CERMAK | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Gould Nursing Home | | A. STATE | | Md. 21218 | |
| | | B. COUNTY | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore | |
| | | D. STREET ADDRESS (If rural, give location) | | 1424 Kingsway Road | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| female | white | widowed | 4/22/84 | 81 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| housewife | | at home | | Czechoslovakia | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| U.S. | | Kostal | | unknown | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | Alma C. Alban, dght. above | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 491X I | | Bronchopneumonia | | 6 days | |
| ANTECEDENT CAUSES | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | Anterior chronic Myocardium | | 5 yrs. | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | | | |
| | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 1965 to Sept 17 1965, that (I) lost saw the deceased alive on Sept 16 1965 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| Dr. Allan Spier | | | | 9/20/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| | | 1501 Pentridge Road, Baltimore, Md., 18 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME of CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) | | |
| Burial | 9/20/65 | Bohemian National Cem. | Baltimore, Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| SEP 21 1965 | Robert E. Taylor | Schimunek Funeral Home, Inc. | | 3331 Brehms Lane | |



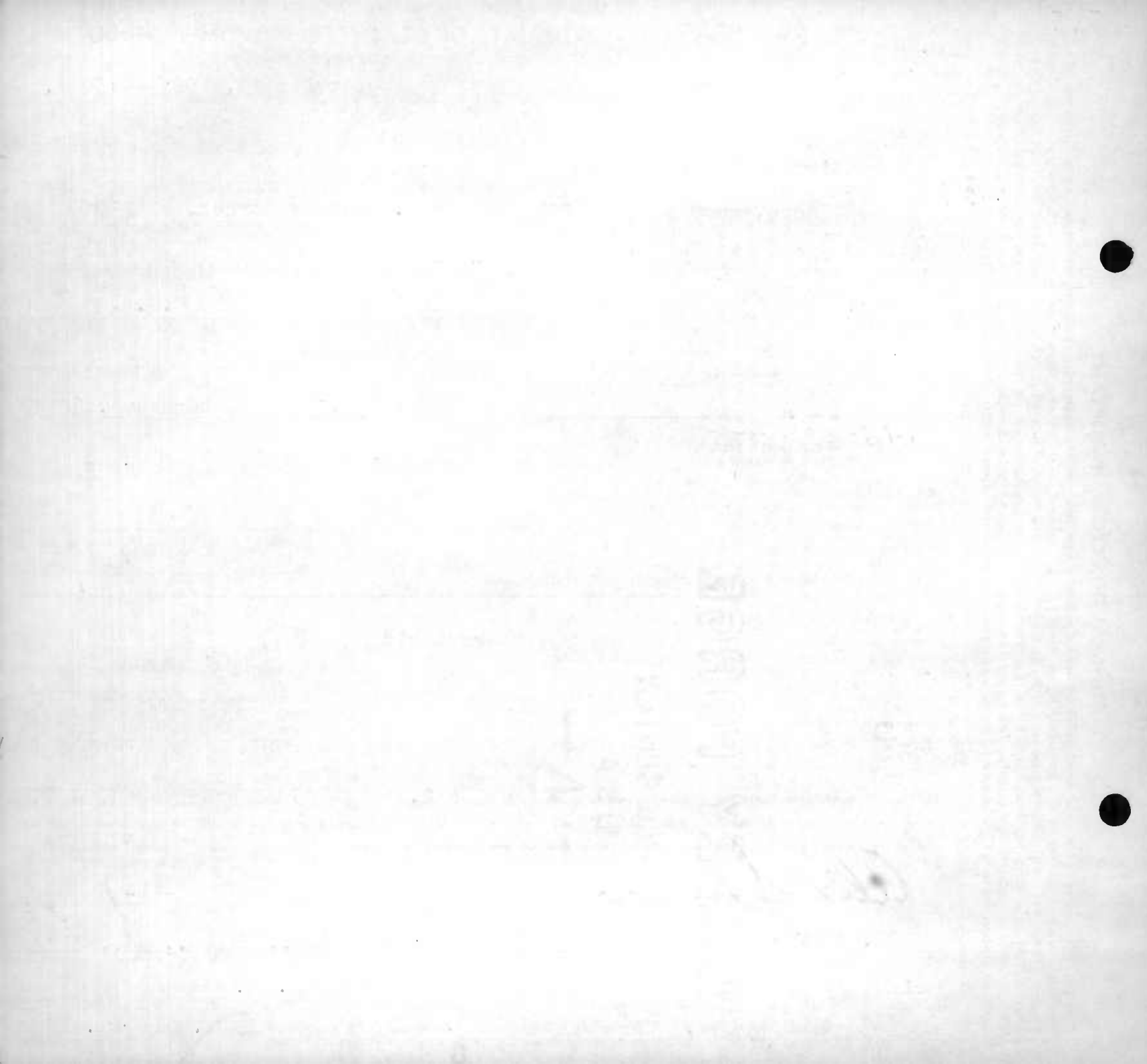
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

[illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

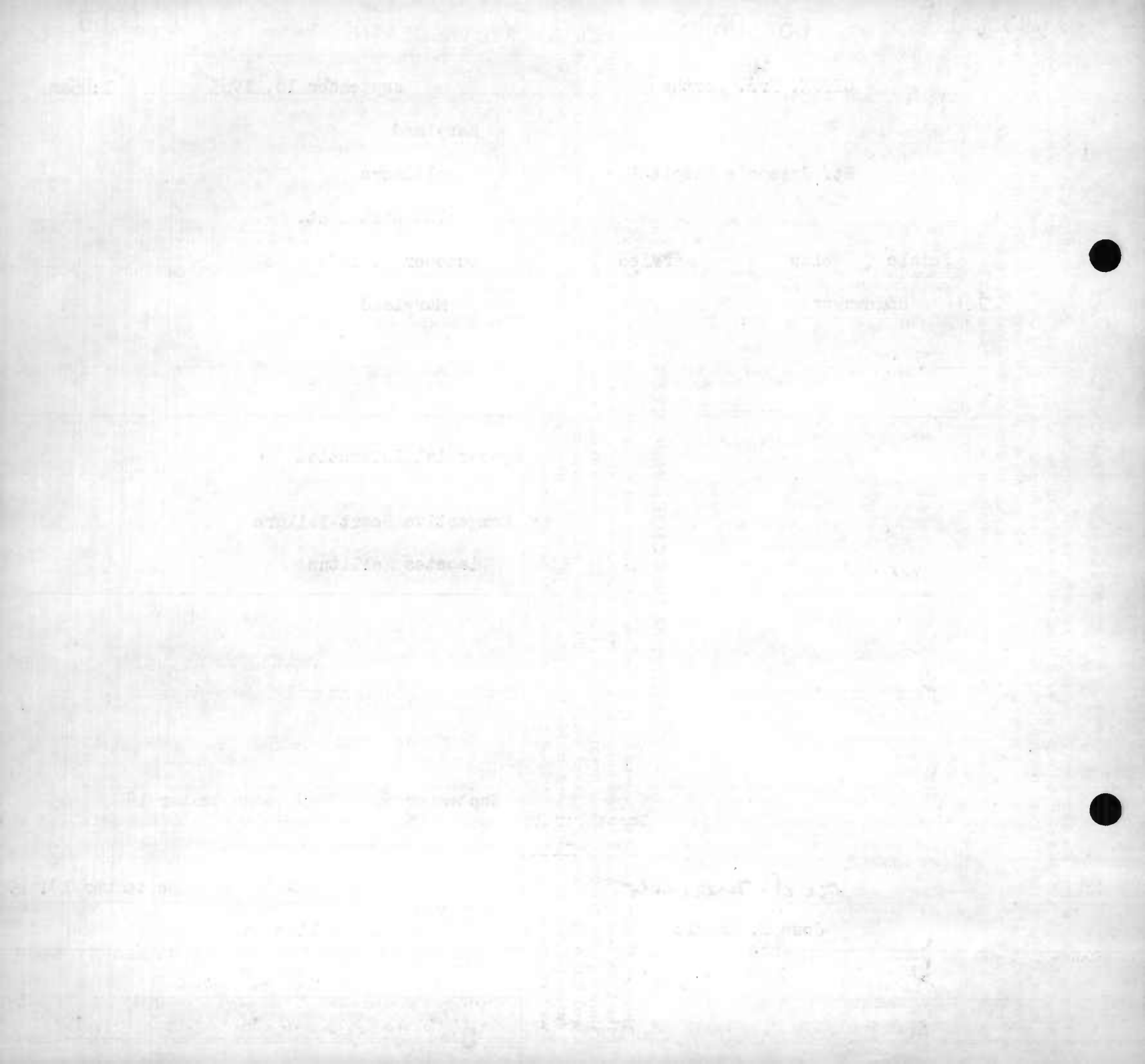
| BIRTH NO. <u>65 9665</u> | | | | BALTIMORE CITY HEALTH DEPARTMENT | | REGISTERED NO. <u>65 9665</u> | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|----------------------------------------------------------------------|--|
| 1. NAME OF DECEASED (Type or Print) <u>James Rogers</u> | | | | 2. DATE AND HOUR OF DEATH <u>September 18, 1965 4:50 A. M.</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland, #21224</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>23-02</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1528 S. Charles Street, #21230</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>7-19-1909</u> | 9. AGE (In years last birthday) <u>56</u> | If Under 1 Yr. Months Days Hours | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u> | | 11. BIRTHPLACE (State or foreign country) <u>Indiana</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>James Rogers</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Rose Wendell</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>RECORDS: BCH, 4940 Eastern Ave., #21224</u> | | | |
| 18. <u>148 X 10021</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Oropharyngeal Carcinoma</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <u>Tuberculosis</u> | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <u>8 Weeks</u> | |
| MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>August 2, 1965</u> to <u>September 18, 1965</u> , that (I) (we) last saw the deceased alive on <u>September 18, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Alex Silverman</u> M.D. | | | | 23B. DATE SIGNED <u>9-18-65</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>DR. ALEX SILVERMAN</u> | | | | 23D. ADDRESS <u>4940 Eastern Ave., Balto., Md., #21224</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9 22 65</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Western</u> | | 24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 21 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Fisher</u> | | 25C. FUNERAL DIRECTOR <u>Mc Cully</u> | | ADDRESS <u>130 E. Fort Ave.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9666 | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|---------------------------------------------------------------------------------------------|---------------------------------------|
| BIRTH NO. 65 9666 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) CITUK, Mrs. Bertha | | 2. DATE AND HOUR OF DEATH September 18, 1965 1:45am M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 26-36 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph's Hospital | | D. STREET ADDRESS (If rural, give location) 6700 Boston St. | | | |
| 5. SEX Female | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH October 6, 1898 | 9. AGE (In years last birthday) 67 | If Under 1 Yr. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO Congestive Heart Failure Diabetes Mellitus | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from September 5, 1965 to September 18, 1965 , that (I) (we) last saw the deceased alive on September 18, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Jose D. Manalo</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED September 18, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Jose D. Manalo | | 23D. ADDRESS 1400 N. Caroline St. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-22-65 | | 24C. NAME OF CEMETERY or CREMATORY St Stanislaus | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 21 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS Walter G. Babcock, 1005 Deylark Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9667 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9667 | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------|-----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------------------------------|------------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Cosmas ANARINO | | | | 2. DATE AND HOUR OF DEATH 9-19-65 1 30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 43 So. Baltimore General Hosp. | | | | A. STATE Md. B. COUNTY 23-02 | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | | D. STREET ADDRESS (If rural, give location) 924 Light St. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH 11/19/00 | 9. AGE (In years last birthday) 64 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam fitter | | | 10B. KIND OF BUSINESS OR INDUSTRY 1 | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME Lawrence Anarino | | | | 14. MOTHER'S MAIDEN NAME Rosa Gentile | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No -- | | | 16. SOCIAL SECURITY NO. 220 09 5454 | | 17. INFORMANT ADDRESS Mrs. Mary Schuerholz 3413 Upton Rd. | | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Acute Pulmonary Edema Arteriosclerotic Cardiovascular Disease | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-19-65 19 to 9-19-65 19, that (I) (we) last saw the deceased alive on 9-19-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Kenneth P. Borovich M.D. | | | | Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-19-65 | |
| 23C. PHYSICIAN'S NAME (Type) Kenneth P. Borovich M.D. | | | | 23D. ADDRESS 1213 Light St. Baltimore Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/22/65 | | 24C. NAME OF CEMETERY or CREMATORY Glen Haven Mem. Pl. | | 24D. LOCATION (City, town, or county) (State) Glen Burnie, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 21 1965 | | 25B. NAME OF REGISTRAR Robert E. Farkas | | 25C. FUNERAL DIRECTOR John P. Conley | | ADDRESS | |

THE
OFFICE OF THE
ATTORNEY GENERAL
WASHINGTON, D. C.
JAN 10 1901

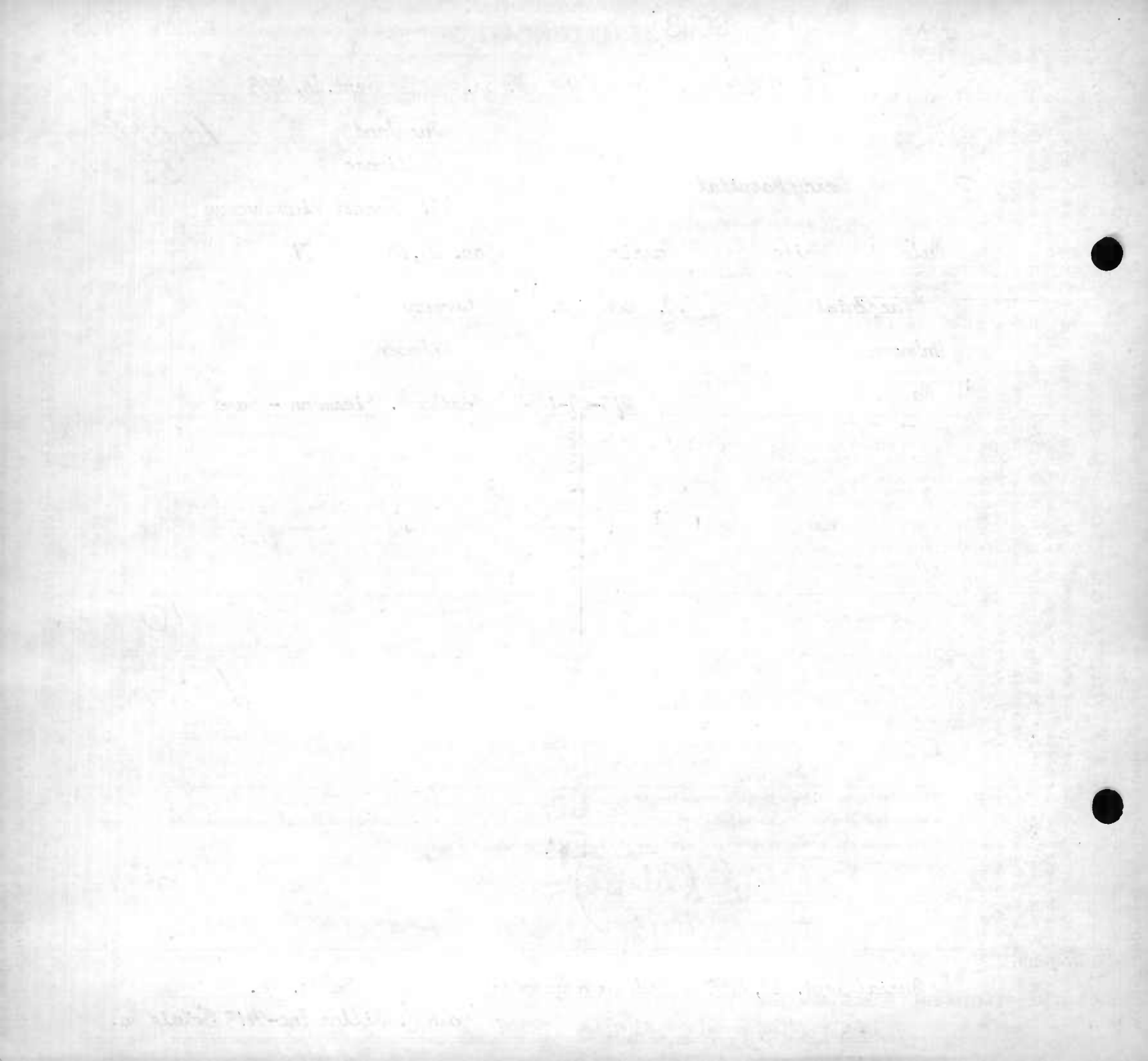
TO THE
HONORABLE
MEMBERS OF THE
HOUSE OF REPRESENTATIVES
WASHINGTON, D. C.
JAN 10 1901

DEAR SIR:
I have the honor to acknowledge the receipt of your letter of the 9th inst. and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

FUNERAL DIRECTOR: IMPORTANT!

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. 65 9668 | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|--------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 65 9668 | | CERTIFICATE OF DEATH | | Registered No. 65 9668 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) EIERMANN Henry W. Sr. | | 2. DATE AND HOUR OF DEATH Sept. 18, 1965 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE Maryland B. COUNTY Balto. | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | D. STREET ADDRESS (If rural, give location) 4513 Forest View Avenue | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Jan. 23, 1894 | 9. AGE (In years lost birth day) 71 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist | | 10B. KIND OF BUSINESS OR INDUSTRY E.J. Codd & Co. | | 11. BIRTHPLACE (State or foreign country) Germany | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 215-09-1848 | | 17. INFORMANT Martha H. Eiermann - Same | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. arteriosclerosis gen'l. | | CAUSE OF DEATH arteriosclerosis gen'l. | | INTERVAL BETWEEN ONSET AND DEATH minutes | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | iliac thrombosis, left | | 10 days | |
| 19A. DATE OF OPERATION 3-9-18-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED gangrene | | 20A. AUTOPSY (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-7-1965 to 9-18-1965 , that (I) (we) last saw the deceased alive on 9-18-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Edward Kelly J. | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-18-65 | |
| 23C. PHYSICIAN'S NAME (Type) J. E. KELLY | | 23D. ADDRESS MERCY HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial Sept. 22, 1965 | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery | |
| 24D. LOCATION (City, town, or county) Balto. Md. | | 24E. (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 21 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Rd. | |
| 25D. ADDRESS | | | | | |



M-470

65 9669

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 9669

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Charles Menzies Mulcahy

2. DATE AND HOUR OF DEATH

9-19-1965

10:00P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)Baltimore City Hospitals
4940 Eastern Avenue
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

704 North Howard Street 21201

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)
Divorced

8. DATE OF BIRTH

12-5-1908

9. AGE (In years
last birthday)

56

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Operating Engineer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John D. Mulcahy

14. MOTHER'S MAIDEN NAME

Ella M. Wolfe

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

217-01-1005

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue 21224

18.

592X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoarthritis, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) Renal Failure

DUE TO

Probable Chronic
GlomerulonephritisAbout
4 weeks

(B) DUE TO

Unknown

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8-17-19 65 to 9-19-19 65,

that (I) (we) last saw the deceased alive on 9-19-19 65 and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Benjamin Hughes

M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

9-19-1965

23C. PHYSICIAN'S
NAME (Type)

Benjamin Hughes

23D. ADDRESS

M.D. 4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

9/23/1965

24C. NAME of CEMETERY or CREMATORY

Loudon Park Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

SEP 21 1965

25B. NAME OF REGISTRAR

Benjamin Hughes

25C. FUNERAL DIRECTOR

John A. Moran Inc 3000 E. Baltimore St.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

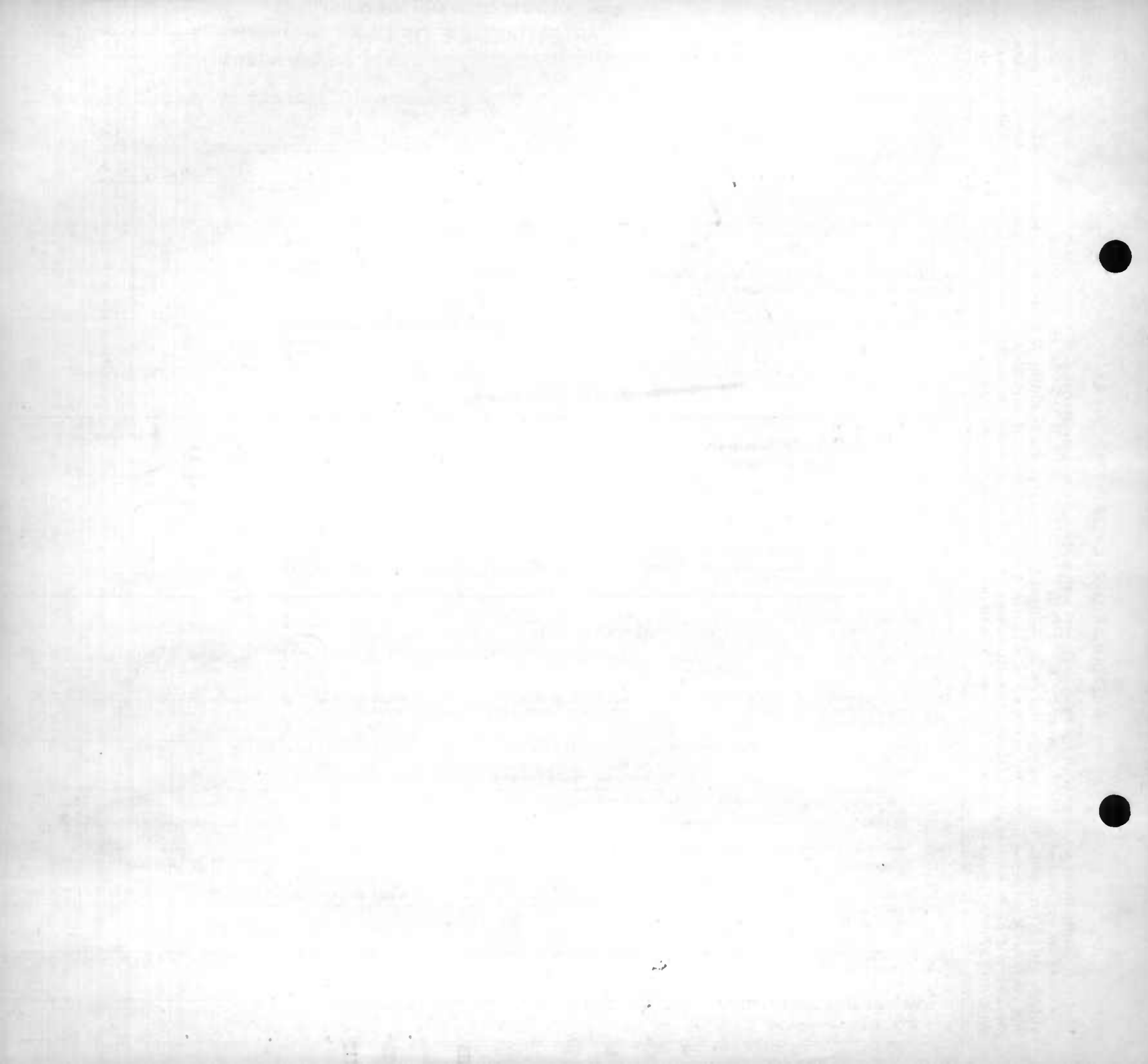
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9670 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9670 | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------|-----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|--------------------------------------------------------------------------------------|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Thomas J. Kroll | | | | 2. DATE AND HOUR OF DEATH 9-16-65 12:40 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Churd Home Hospital | | | | A. STATE Maryland B. COUNTY 2-02 | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 251 S. Broadway | | | |
| 5. SEX Male | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH 1-3-03 | 9. AGE (In years lost birthday) 62 | If Under 1 Yr. Months Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Burner | | 10B. KIND OF BUSINESS OR INDUSTRY Patpasco Scrap Corp. | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME George Kroll | | | | 14. MOTHER'S MAIDEN NAME Mary? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 180-07-5274 | | 17. INFORMANT Mrs. Vivian G. Kroll | | ADDRESS 251 S. Broadway | |
| 18. 199.2-1002.1 186-01-8274 CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Carcinoma, liver + adrenal + lung | | | | (A) DUE TO | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | | | |
| | | | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pulmonary T. B. Acute(?) | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-12 19 65 to 9-16 19 65 , that (I) (we) last saw the deceased alive on 9-16 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE José S. Maisig | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-16-65 | |
| 23C. PHYSICIAN'S NAME (Type) José S. Maisig | | M.D. | | 23D. ADDRESS Churd Home Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/20/65 | | 24C. NAME OF CEMETERY or CREMATORY Peters Cemetery | | 24D. LOCATION (City, town, or county) (State) Venango County, Pennsylvania | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 21 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR ADDRESS John A. Moran, Inc. 3000 E. Baltimore St. | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|---------------------------------------------------------------------------------------------------------------|--|--|--|--|
| BIRTH NO. | | | | | CERTIFICATE OF DEATH | | | | | Registered No. | | | | |
| 1. NAME OF DECEASED (Type or Print) MAXA, MR. FRANK L. | | | | | 2. DATE AND HOUR OF DEATH 9-20-65 2:45 A.M. | | | | | 65 9671 | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 CHURCH HOME AND HOSPITAL | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 6-01 | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) 31 N. POTOMAC ST. BALTO. 24 | | | | |
| D. STREET ADDRESS (If rural, give location) Baltimore | | | | | 5. SEX M | | | | | 6. RACE W | | | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | | | | | 8. DATE OF BIRTH 6-19-98 | | | | | 9. AGE (In years last birthday) 68 yrs. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EMPLOYEE (DISTILLERY) | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country) EUROPE | | | | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | 13. FATHER'S NAME PROKOP MAXA | | | | | 14. MOTHER'S MAIDEN NAME JOSEPHINE GOKOT | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or time of service) | | | | | 16. SOCIAL SECURITY NO. | | | | | 17. INFORMANT ELIZABETH MAXA | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 163X I | | | | | CAUSE OF DEATH (A) CARCINOMA OF LUNG DUE TO (B) METASTASIS TO VITAL ORGANS DUE TO (C) CONGESTIVE HEART FAILURE | | | | | INTERVAL BETWEEN ONSET AND DEATH 2-3 yrs. | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) | | | | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | |
| 21F. HOW DID INJURY OCCUR? | | | | | 22. I certify that (I) (this hospital) attended the deceased from 9-18-1965 to 9-20-1965 , that (I) (we) last saw the deceased alive on 9-19-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Jose Ortiz | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | 23B. DATE SIGNED 9-20-65 | | | | |
| 23C. PHYSICIAN'S NAME (Type) Jose Ortiz | | | | | 23D. ADDRESS M.D. | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | | 24B. DATE 9/23/65 | | | | | 24C. NAME of CEMETERY or CREMATORY Sacred Heart Cemetery | | | | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | | | 25A. DATE REC'D BY HEALTH DEPT. SEP 21 1965 | | | | | 25B. NAME OF REGISTRAR Robert J. Talbot | | | | |
| 25C. FUNERAL DIRECTOR John A. Moran, Inc. | | | | | ADDRESS 3000 E. Baltimore St. | | | | | | | | | |



J-525

CERTIFICATE OF DEATH

Registered No. 65 9672

| | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|---------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. 65 9672 | | 1. NAME OF DECEASED (Type or Print) <i>Johnson Franklin R</i> | | 2. DATE OF DEATH <i>Sept. 19, 1965</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Union Memorial Hospital</i> <i>Baltimore, Maryland</i> | | | | A. STATE <i>Baltimore</i> B. COUNTY <i>Maryland</i> C. CITY OR TOWN <i>Baltimore</i> (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) <i>8310 Edgemoor Rd. Baltimore 34, Md</i> | |
| 5. SEX <i>M.</i> | 6. COLOR OR RACE <i>W.</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH <i>Sept. 19-1965</i> | 9. AGE (In years last birthday) <i>29</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Elmer C. Johnson</i> | | | 14. MOTHER'S MAIDEN NAME <i>Eunice M. Mohler</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes</i> | | 16. SOCIAL SECURITY NO. <i>214-30-4654</i> | | 17. INFORMANT ADDRESS | |
| 18. 75221 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | (A) <i>Ulcerative Colitis</i> DUE TO (B) <i>dead small bowel segmental</i> DUE TO (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II <i>3</i> | | 19a. DATE OF OPERATION <i>9/17/65</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>multiple small bowel fistula</i> | |
| 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/> | | | |
| 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>March 25</i> 19 <i>65</i> to <i>Sept. 19</i> 19 <i>65</i> that (I) (we) last saw the deceased alive on <i>Sept. 19</i> 19 <i>65</i> and that in (my) (our) opinion death occurred at _____ m., from the causes and on the date stated above. | | | | | |
| 23a. SIGNATURE <i>John A. Moran</i> ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M. D. | | 23b. ADDRESS <i>Union Memorial Hosp. Baltimore Md.</i> | | 23c. DATE SIGNED <i>Sept-19-65</i> | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i> | | 24b. DATE <i>9-20-65</i> | | 24c. NAME OF CEMETERY OR CREMATORY <i>Greenmount Cemetery</i> | |
| 24d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | | 25a. DATE REC'D BY HEALTH DEPT. <i>SEP 21 1965</i> | | | |
| 25b. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i> | | 25c. FUNERAL DIRECTOR ADDRESS <i>John A. Moran, Inc. 4201 York Road</i> | | | |

THIS IS A PERMANENT RECORD.
EVERY ITEM OF INFORMATION SHOULD BE CAREFULLY SUPPLIED.
PLEASE WRITE THE CAUSES OF DEATH CLEARLY AND LEGIBLY.

Aug. 10/13/65

CONFIDENTIAL

SECRET

EXHIBIT

SECRET

SECRET

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

FUNERAL DIRECTOR: IMPORTANT

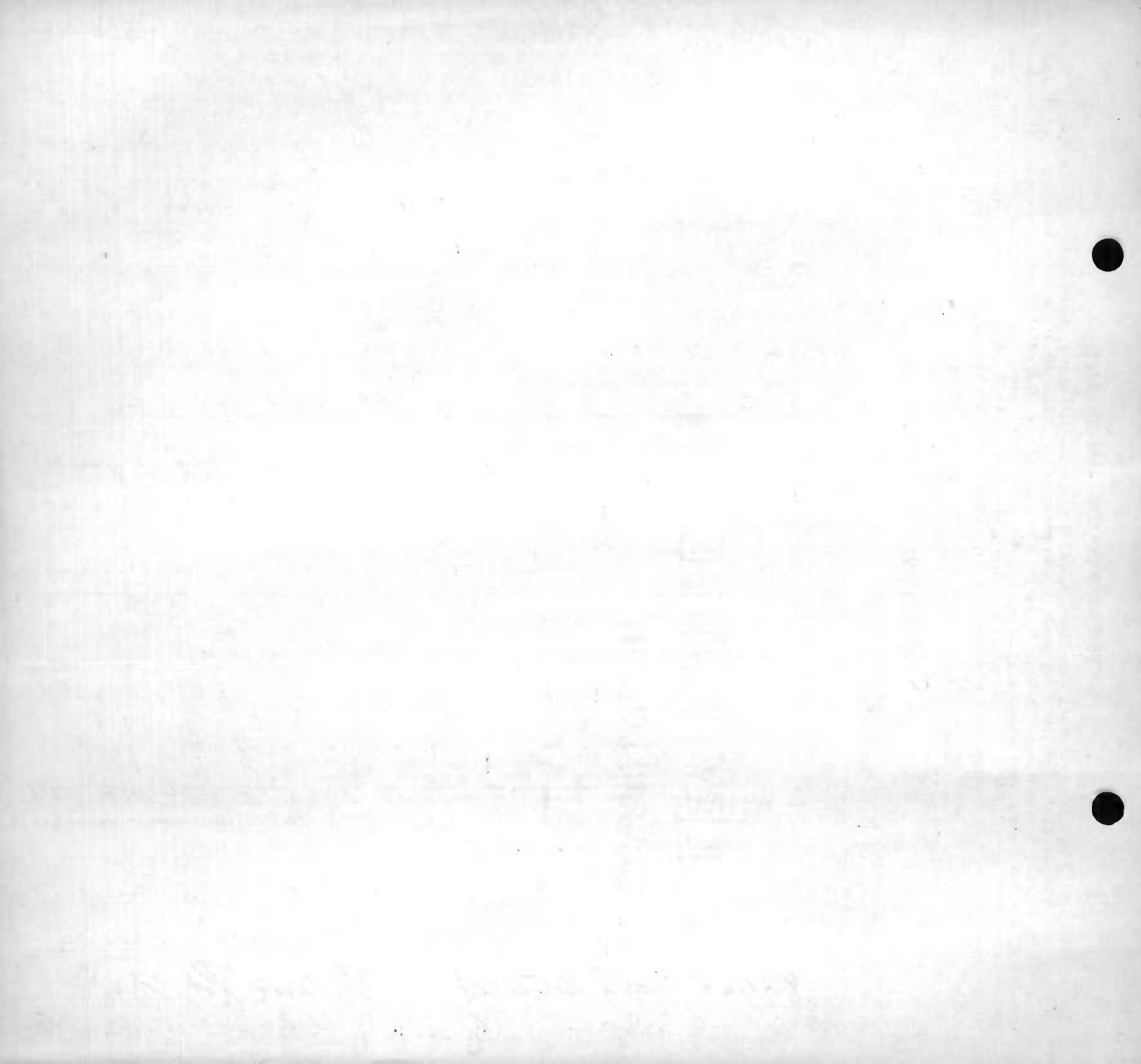
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|--------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|----------------------------------------------------------------------------|------------------------------------------|
| BIRTH NO. 65 9673 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65-9673 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | 65-9673 | |
| 1. NAME OF DECEASED (Type or Print) <i>Mrs. W. Travers</i> | | 2. DATE AND HOUR OF DEATH <i>9/19/65 9 30 P.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Lake Drive Nursing Home</i> | | A. STATE <i>Maryland</i> | | B. COUNTY <i>12-01</i> | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | D. STREET ADDRESS (If rural, give location) <i>2215 Huntington Ave.</i> | | | |
| 5. SEX <i>Female</i> | 6. RACE <i>W.H.T.</i> | MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>WIDOWED</i> | 8. DATE OF BIRTH <i>Jan. 8-1889</i> | 9. AGE (In years last birthday) <i>76</i> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Stafford County, Virginia</i> | |
| 13. FATHER'S NAME <i>Edward West</i> | | 14. MOTHER'S MAIDEN NAME <i>Victoria</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>No</i> | | 17. INFORMANT ADDRESS <i>Mr. Joseph N. Travers 1268 Cedarcroft Rd.</i> | |
| 18. <i>420.1</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | (A) <i>Coronary Thrombosis</i> | | <i>Sudden</i> | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) <i>Arteriosclerotic Heart Dis.</i> | | <i>Years</i> | |
| | | (C) <i>Art. Sclerosis</i> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <i>Chronic Brain Syndrome</i> | | <i>Years</i> | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Aug 6 1962</i> to <i>Sept 19 1962</i> , that (I) (we) last saw the deceased alive on <i>Sept 16 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Louis V Blum</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>9/19/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Louis V Blum</i> | | 23D. ADDRESS <i>3205 W. Rogers Ave Balto 21205 Md</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>9/22/65</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Moreland Memorial Park</i> | |
| 24D. LOCATION (City, town, or county) <i>Baltimore, Maryland</i> | | 24E. DATE REC'D BY HEALTH DEPT. <i>SEP 21 1965</i> | | 24F. NAME OF REGISTRAR <i>John A. Brown</i> | |
| 24G. ADDRESS <i>3000 E. Baltimore St.</i> | | 24H. NAME OF REGISTRAR <i>John A. Brown</i> | | 24I. ADDRESS <i>3000 E. Baltimore St.</i> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9674 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9674 | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|-------------------------------------------------------------------|----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--------------------------------------------------------------------------|-----------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) JOHN H. COLEMAN | | | | 2. DATE AND HOUR OF DEATH Sept. 17, 1965 9:35 p.m. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQUARE HOSP. | | | | A. STATE B. COUNTY MARYLAND 13-06 | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 3310 CHESTNUT AVE. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH MAY 21, 1906 | 9. AGE (In years last birthday) 59 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MAIL CARRIER U.S. GOV. | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) ARKANSAS | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME SAMUEL H. COLEMAN | | | | 14. MOTHER'S MAIDEN NAME ELLA GAINES | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES H-W-II | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT MARTHA COLEMAN | | ADDRESS SAME | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) URINARY BLADDER CARCINOMA 2 years DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH 2 years | | | | | | | |
| 19. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept. 2 1965 to Sept. 17 1965, that (I) (we) lost saw the deceased alive on Sept. 17 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Merita Suarez | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Sept 17, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) MERITA SUAREZ | | | | 23D. ADDRESS FRANKLIN SQUARE HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/21/65 | | 24C. NAME of CEMETERY or CREMATORY Baltimore National | | 24D. LOCATION (City, town, or county) (State) Frederick Rd, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT SEP 21 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Curtis E. Brown 3818 Grand Ave | | | |



FUNERAL DIRECTOR: IMPORTANT

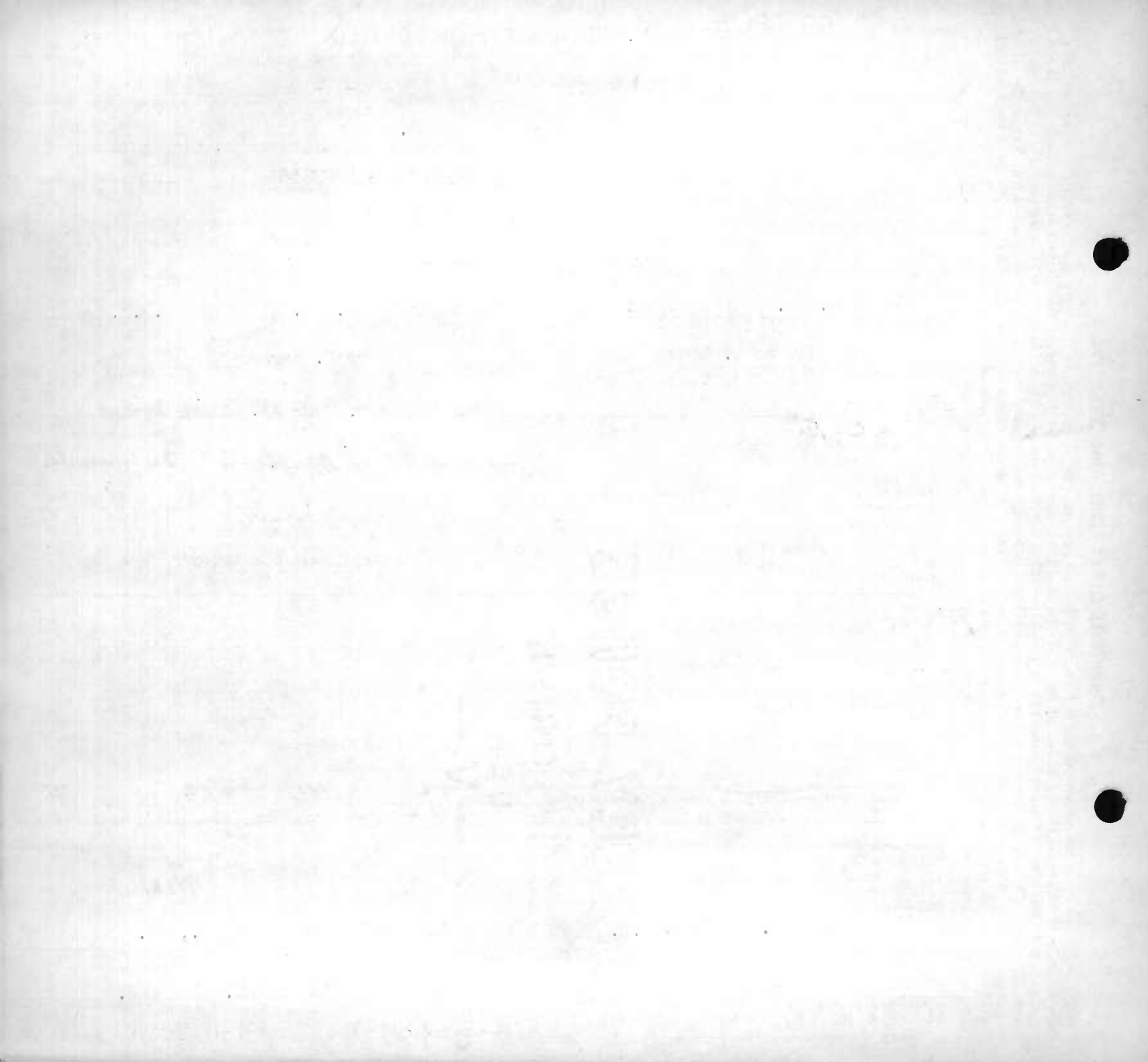
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9675 | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 65 9675 | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) | | Mrs. Vivian Mae White | | 2. DATE AND HOUR OF DEATH Sept. 19, 1965 - 11:20 AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Church Home and Hospital | | A. STATE Maryland B. COUNTY Baltimore | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 4217 Fullerton Ave. | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 1-19-1908 | 9. AGE (In years last birthday) 57 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME Silliam Giffin | | 14. MOTHER'S MAIDEN NAME unknown Ella J. Warfield | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217-12-6916 | | 17. INFORMANT ADDRESS Mr Robert L. White 4217 Fullerton Ave. 36 | |
| 18. 323X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Cerebral cortical atrophy DUE TO (B) Multiple drug addiction DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH years years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 9/9/1965 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <u>this hospital</u> attended the deceased from <u>August 30, 1965</u> to <u>September 18, 1965</u> , that (I) (we) last saw the deceased alive on <u>Sept 18, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Jose R. Rosti</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9/18/1965 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS M.D. Church Home Hospital Balto. Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9-21-1965 | 24C. NAME of CEMETERY or CREMATORY Union Chapel Cemetery | | 24D. LOCATION (City, town, or county) (State) Harford Co. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR Robert E. Fisher | 25C. FUNERAL DIRECTOR Joseph J. General | | ADDRESS (36) 7401 Belair Road | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|---------------------------------------------------------------------------|-----------------------------------------------|--|
| 65 9676 | | | | | Registered No. 65 9676 | | | | |
| BIRTH NO. | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) Benjamin Fred Long | | | | | 2. DATE AND HOUR OF DEATH 9-17-1965 M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Joseph's Hospital | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, Maryland D. STREET ADDRESS (If rural, give location) 337 Elinor Avenue #36 | | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 1-31-1910 | 9. AGE (In years last birthday) 55 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret Balto. Co. | | | 10B. KIND OF BUSINESS OR INDUSTRY Policeman | | 11. BIRTHPLACE (State or foreign country) St Mary's Co. Md. | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Thomas L. Long | | | | | 14. MOTHER'S MAIDEN NAME Cora V. Harper | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs Amelia H. Long | | | ADDRESS 337 Elinor Avenue | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction | | | | | INTERVAL BETWEEN ONSET AND DEATH 20 minutes | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Coronary Thrombosis | | | | | 20. DUE TO Arterio Sclerotic Cardiovascular disease | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 60 to 9/17 19 65 , that (I) (we) last saw the deceased alive on 9/13 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Paul G. Mueller | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED 9/18/65 | |
| 23C. PHYSICIAN'S NAME (Type) Paul G. Mueller, M.D. | | | | | 23D. ADDRESS 6411 Belair Road Balto., Md. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-21-1965 | | 24C. NAME of CEMETERY or CREMATORY Gardens of Faith Cemetery | | | 24D. LOCATION (City, town, or county) (State) Baltimore Co. Md. | | |
| 25A. DATE RECD BY HEALTH DEPT. SEP 21 1965 | | | 25B. NAME OF REGISTRAR Robert E. Fisher | | | 25C. FUNERAL DIRECTOR Joseph J. Funeral Home | | | |
| ADDRESS (36) 7401 Belair Road | | | | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|--------------------------------------------|
| BIRTH NO. 65 9677 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9677 | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) <i>Swallow, Effie B.</i> | | | 9-19-65 10:45 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Church Home & Hospital</i> | | | A. STATE <i>MD</i> B. COUNTY <i>Baltimore</i> | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | |
| | | | D. STREET ADDRESS (If rural, give location) <i>4 EAST 2ND ST.</i> | | |
| | | | 18 | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH <i>5-13-72</i> | 9. AGE (In years last birthday) <i>93</i> | 10. CITIZEN OF WHAT COUNTRY? <i>USA</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Never worked</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>—</i> | 11. BIRTHPLACE (State or foreign country) <i>MD</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> |
| 13. FATHER'S NAME <i>Dr. John Swallow</i> | | | 14. MOTHER'S MAIDEN NAME <i>Mary Snyder</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | 16. SOCIAL SECURITY NO. <i>None</i> | | |
| | | | 17. INFORMANT <i>The Church Home and Hospital Records</i> | | |
| 18. <i>1553.81</i> | | | CAUSE OF DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | (A) DUE TO <i>CA of Colon</i> | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO <i>CA of Colon</i> | | |
| | | | (C) DUE TO <i>CA of Colon</i> | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | <i>Popliteal Thrombosis @</i> | | |
| 19A. DATE OF OPERATION <i>Oct. 1964</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>CA of Colon</i> | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <i>No</i> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>No</i> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>No</i> | |
| 21D. TIME OF INJURY (APPROX.) <i>No</i> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <i>—</i> | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9-13-65</i> to <i>9-19-65</i> that (I) (we) last saw the deceased alive on <i>9-19-65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Asst. M.D.</i> | | | | 23B. DATE SIGNED <i>9-19-65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Antonio S.C. Fernuio</i> | | | | 23D. ADDRESS <i>Church Home & Hospital</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>9/23/1965</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Druid Ridge Cemetery</i> | |
| | | | | 24D. LOCATION (City, town, or county) (State) <i>Pikesville, Maryland</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 21 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Starkey</i> | | 25C. FUNERAL DIRECTOR <i>Wm. J. Fisher</i> | |
| | | | | ADDRESS <i>Baltimore, Md. 21217</i> | |

Church House & Hospital

F W

John E. M. H. W.

East 2nd St.

2-12-12

MD

West 2nd St.

Co of Colon

Co of Colon

Co of Colon

Polynomial Transverse

West 1st St. & 2nd St.

no

no

no

no

91-P

91-P

Church House & Hospital

John E. M. H. W.

Church House & Hospital

no

65 9678

BALTIMORE CITY HEALTH DEPARTMENT

65 9678

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

SARAH B. QUINN

2. DATE AND HOUR PRONOUNCED DEAD

September 20, 1965 2:20 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

10-14-65

3925 Beech Avenue

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3925 Beech Avenue

21211

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

April 22, 1883

9. AGE (In years
last birthday)

82

If Under 1 Yr. II Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

John Brady

14. MOTHER'S MAIDEN NAME

Sarah Ann Printy

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

Mrs. Mercedes Bromwell Baltimore, Md. 12

ADDRESS

18.

603 X I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Pyonephrosis due to stricture of the
pyonephrosis x ureteropelvic junction bilaterally
stricture of the ureteropelvic
junction bilaterally

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9-20-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Cremation

23B. DATE

9/24/1965

23C. NAME of CEMETERY or CREMATORY

Loudon Park Crematory

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

SEP 21 1965

24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Wm. J. Fisher & Son Baltimore, Md. 21217

ADDRESS

Letter from M.E.'s office

10-14-65

M.H.

VALLEY FORGE

FOR CONTENT

OF A

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

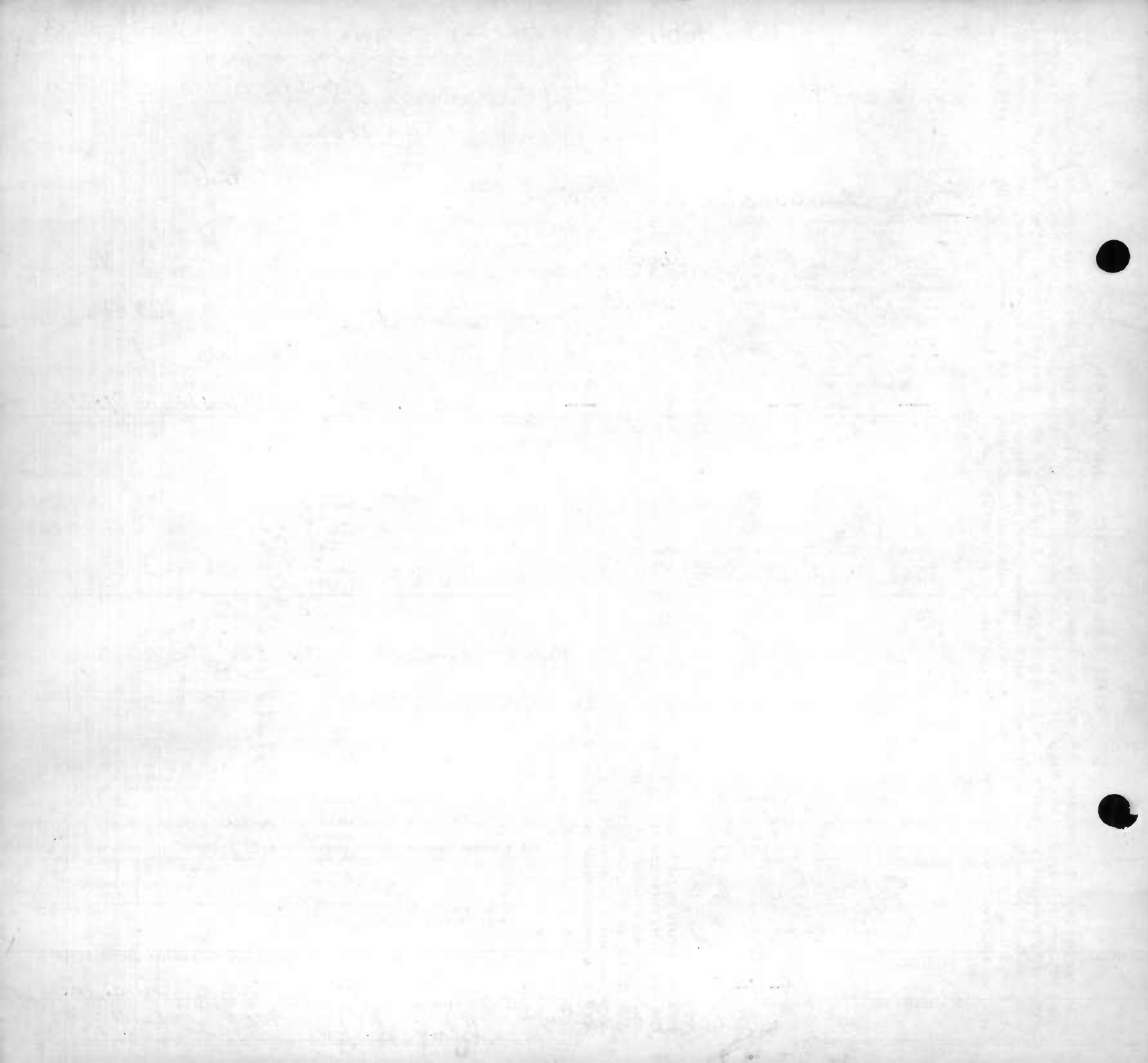
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9679 | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|
| BIRTH NO. 65 9679 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) SUTTON, CHARLES CLAYTON | | 2. DATE AND HOUR OF DEATH 9-18-65 4¹⁰ A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL | | A. STATE MD B. COUNTY Balto | | | |
| 5. SEX MALE | | 6. RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | |
| 8. DATE OF BIRTH 10-24-89 | | 9. AGE (In years lost birthday) 75 | | 10. If Under 1 Yr. Months Days Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Block operator | | 10B. KIND OF BUSINESS OR INDUSTRY PA- Railroad | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Jefferson Sutton | | 14. MOTHER'S MAIDEN NAME ELIZABETH COOPER | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 717-07-7896 | | 17. INFORMANT Mrs. Mattie Sutton, 426 Register Ave., Baltimore, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH Pulmonary embolism | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) | | (A) DUE TO | | (B) DUE TO | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 9-4-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Secondary closure wound | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <u>this hospital</u> attended the deceased from 6-28 19 65 to 9-18 19 65 , that (I) <u>we</u> last saw the deceased alive on 9-17 19 65 and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>We</u> (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Brian H. Gross | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-18-65 | |
| 23C. PHYSICIAN'S NAME (Type) BRIAN H. GROSS | | 23D. ADDRESS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-21-65 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Zion Cemetery, Freeland, Md. | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. SEP 21 1965 | | 25B. NAME OF REGISTRAR Robert E. Talbot | |
| 25C. FUNERAL DIRECTOR J. J. Henderson, New Freedom, Pa. | | ADDRESS | | | |

11/65 - Hydronephrosis
Uretero-vesical obstruction
Prostatic hypertrophy
Retention of urine - post-op
Cause for which operation performed - urinary fistula
from suprapubic prostatic abscess
Inform received from Union mem. Hays - see Doc't file
Bur. of Statistics - American Red Cross

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

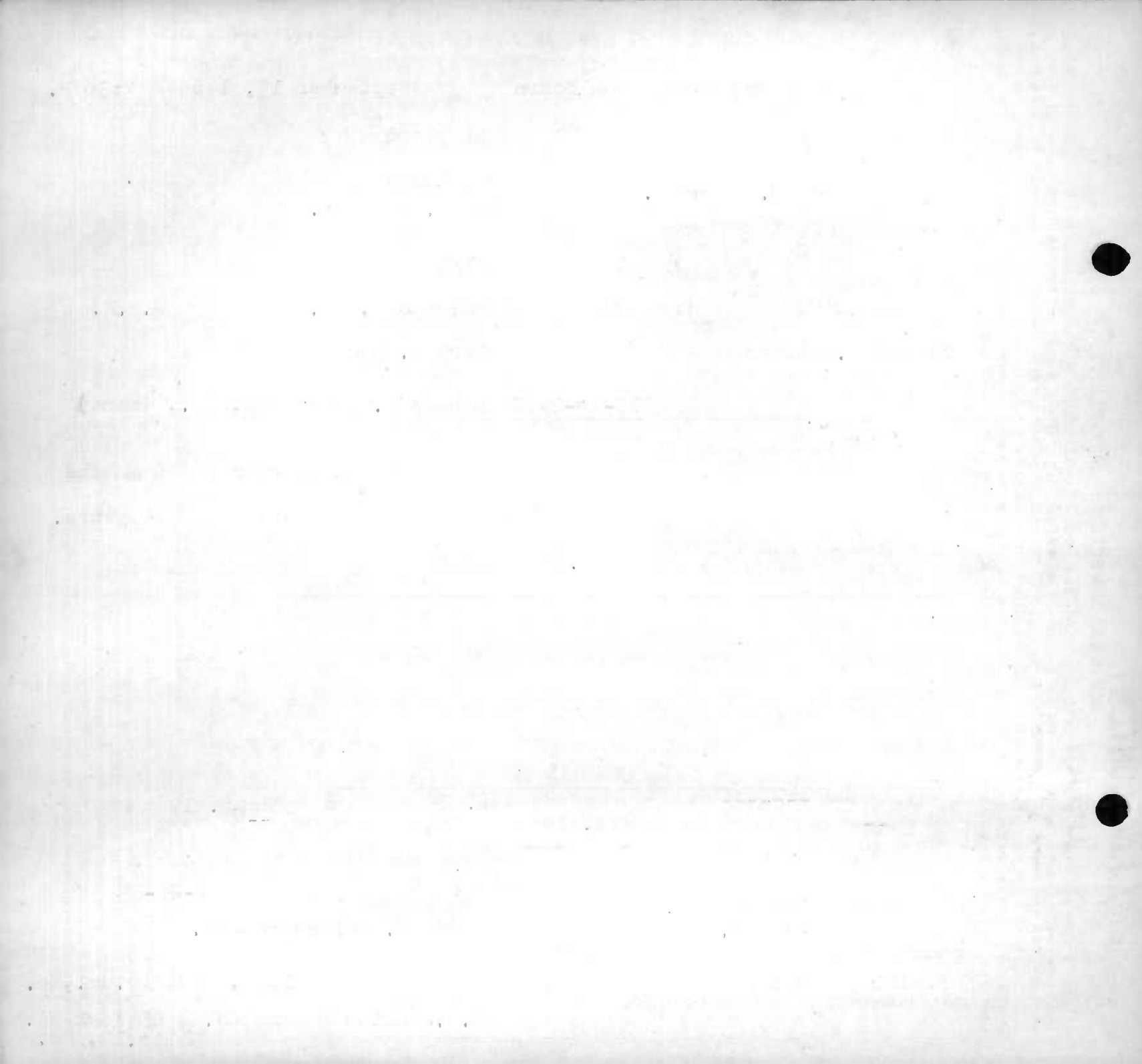
| | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. 65-24025 65 9680 | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 9680 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | Registered No. | |
| 1. NAME OF DECEASED (Type or Print) Baby Girl Maggio | | 2. DATE AND HOUR OF DEATH September 19 1965 10:45 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND 34 FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BON SECOURS HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Balto C. CITY OR TOWN (If outside city, limits, write RURAL and give township) BALTIMORE #6 59-00 D. STREET ADDRESS (If rural, give location) 2320 HAMILTOWN CIRCLE | | | |
| 5. SEX Female | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH 9-19-65 | 9. AGE (in years lost birthday) 12 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn | | 10B. KIND OF BUSINESS OR INDUSTRY Infant | | 11. BIRTHPLACE (State or foreign; country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Rocco A. Maggio | | | |
| 14. MOTHER'S MAIDEN NAME MARY M. HUFNAGEL | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. No | | 17. INFORMANT Rocco A. Maggio 2320 Hamilton Circle | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 773.01 POLYHYDRAMNIOS Fracture | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION O | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Samuel C. Chu | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) SAMUEL C. CHU | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-21-65 | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery | |
| 24D. LOCATION (City, town, or county) (State) 4430 Belair Road Balto. Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 21 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Charles J. Jiles | | | |
| 25D. ADDRESS 9015 CONKLING ST. BALTO., 24, M.D. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9681 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9681 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|--------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|-----------------------------------------------------------------------------|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Margaret Waters Coulbourn | | | | 2. DATE AND HOUR OF DEATH September 19, 1965 7:30 P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 13-07 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 616 W. 40th St. | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| D. STREET ADDRESS (If rural, give location) 616 W. 40th St. | | | | | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH 4/1/1895 | 9. AGE (In years last birthday) 70 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Albert E. Waters | | | | 14. MOTHER'S MAIDEN NAME Mary S. Hooper | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217-18-2997 | | 17. INFORMANT ADDRESS Robert M. Coulbourn, Jr., (Same) | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 170X I Generalized Carcinomatosis DUE TO Carcinoma of the breast | | | | INTERVAL BETWEEN ONSET AND DEATH 6 months 10 years. | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept. 25 1962 to Sept. 19 1965, that (I) (we) lost saw the deceased alive on Sept. 19 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE John M. Scott | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9-20-65 | |
| 23C. PHYSICIAN'S NAME (Type) John M. Scott | | | | 23D. ADDRESS 600 W. Belvedere Ave. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/22/1965 | | 24C. NAME of CEMETERY or CREMATORY Druid Ridge | | 24D. LOCATION (City, town, or county) (State) Pikesville, Balto.Co., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 21 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>65 9682</u> | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------|
| BIRTH NO. <u>65 9682</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Julia C. Hamilton</u> | | 2. DATE AND HOUR OF DEATH <u>September 18, 65 5¹⁰ A. M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>33 THE JOHNS HOPKINS HOSPITAL</u> | | A. STATE <u>NEW YORK</u> B. COUNTY <u>V-29</u> | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>ENDICOTT</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>5 HILLSIDE COURT</u> | | | |
| 5. SEX <u>FEMALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>8-11-41</u> | 9. AGE (In years last birthday) <u>24</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Public Health Nurse Gov't.</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <u>Indiana</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>DANA S. COPE</u> | | | 14. MOTHER'S MAIDEN NAME <u>MARY B. BAUGHAN</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. | 17. INFORMANT <u>Stephen B. Hamilton</u> | | |
| | | | ADDRESS <u>Above</u> | | |
| 18. <u>410 X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | <u>(A) Ventricular tachycardia</u> <u>Rheumatic carditis,</u> <u>in active with mitral</u> <u>stenosis (severe) and tri-</u> <u>cuspid stenosis (minimal)</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u> | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>September 8</u> 19 <u>65</u> to <u>September 18</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>September 17</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>W.B. Daniels, Jr.</u> | | M.D. | Attending Phys. <input checked="" type="checkbox"/> | Med. Director <input type="checkbox"/> | Staff Phys. <input type="checkbox"/> |
| 23B. DATE SIGNED <u>9/18/65</u> | | | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>W. B. DANIELS, Jr.</u> | | M.D. | 23D. ADDRESS <u>11 E. Chase St., Baltimore, Md.</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>9-21-65</u> | 24C. NAME of CEMETERY or CREMATORY <u>Moreland Memorial</u> | | 24D. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 21 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u> | | 25C. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u> | |
| | | | | ADDRESS <u>4905 York Rd. Balto., Md.</u> | |



BIRTH NO. 65 9683 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 9683

M.E. CASE NO.

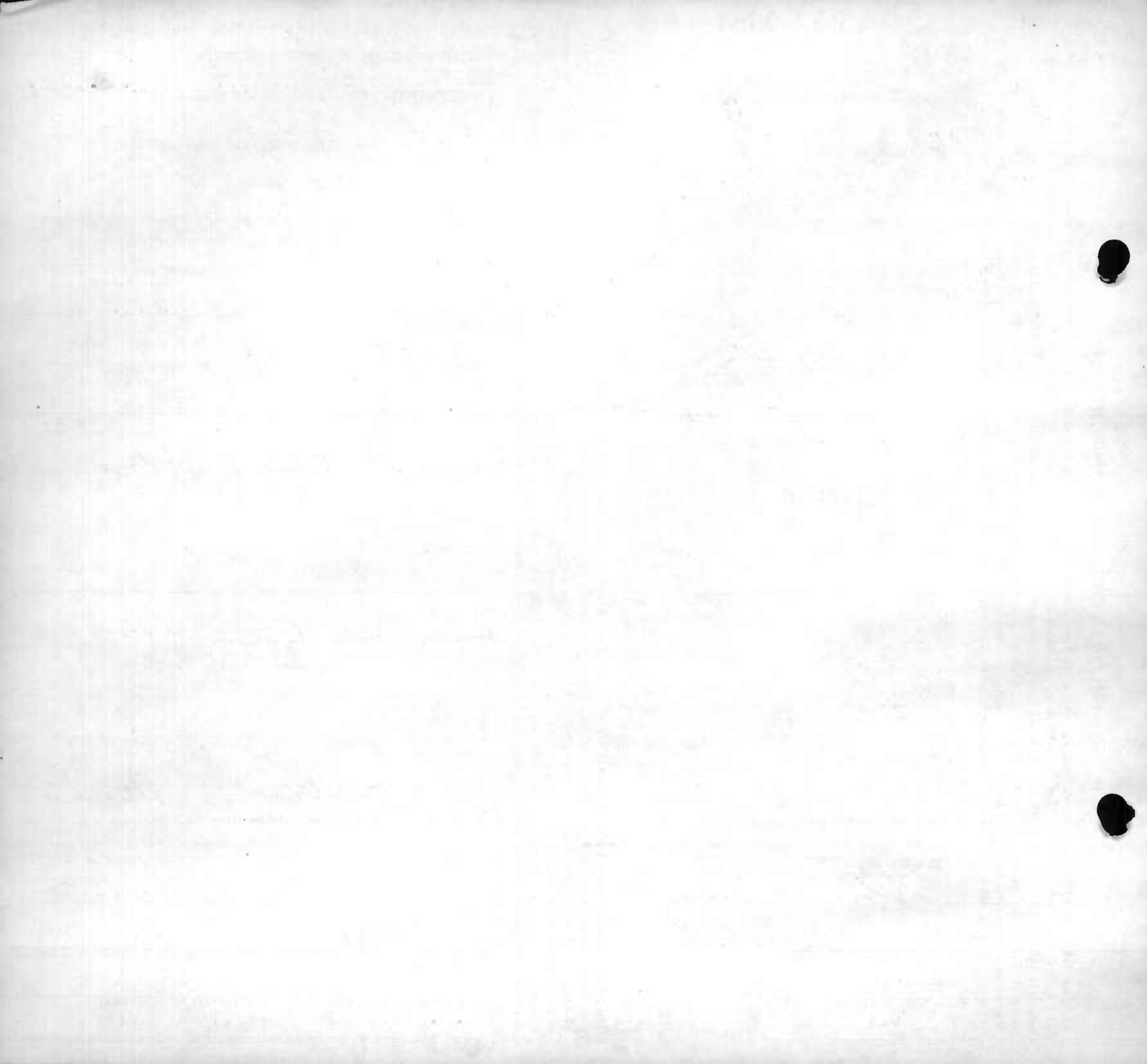
| | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print) C. Gordon Algire | | 2. DATE AND HOUR PRONOUNCED DEAD September 19, 1965 5:30 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 524 Castle Drive | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH April 5, 1905 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer | | 10B. KIND OF BUSINESS OR INDUSTRY Ellicott-Brandt Co. | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. |
| 13. FATHER'S NAME Charles T. Algire | | 14. MOTHER'S MAIDEN NAME Helen L. Newman | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 216-09-6474 | 17. INFORMANT Mrs. Betty Algire |
| | | ADDRESS (Same) | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 9/22/1965 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D. | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 9/22/1965 | |
| 23C. NAME OF CEMETERY or CREMATORY Druid Ridge | | 23D. LOCATION (City, town, or county) (State) Pikesville, Balto. Co., Md. | |
| 24A. DATE REC'D BY HEALTH DEPT. SEP 21 1965 | | 24B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 24C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. | | 24D. ADDRESS 1905 York Rd. Balto. 12, Md. | |

WALTON & HOUGHTON

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BALTIMORE CITY HEALTH DEPARTMENT | | BIRTH NO. 65 9684 | | REGISTERED NO. 65 9684 | |
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) KAZIMIERZ J. PRZYBYLSKI | | | 2. DATE AND HOUR OF DEATH September 20, 1965 6:50 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2-03 | | |
| 9. FULL NAME OF HOSPITAL OR INSTITUTION House in the Pines Nursing Home 2525 W. Belvedere Ave. | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) 521 S. Ann Street | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 1/3/1882 | 9. AGE (In years last birthday) 83 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stevedore | | | 10B. KIND OF BUSINESS OR INDUSTRY Ship cargo Loading | | 11. BIRTHPLACE (State or foreign country) Poland |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | |
| 13. FATHER'S NAME Joseph Przybylski | | | 14. MOTHER'S MAIDEN NAME Katharine Fabiszak | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 215-05-0332 | | 17. INFORMANT Mrs. Sophia Przybylski |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 490X I (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Right Lower Lobe Pneumonia | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 3 days |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic Brain Syndrome | | 3 years |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/19 2/17 1969 to 9/20 1965 , that (I) (we) last saw the deceased alive on 9/19 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Albert B. Bradley | | | | 23B. DATE SIGNED 9/21/65 | |
| 23C. PHYSICIAN'S NAME (Type) Albert B. Bradley | | | | 23D. ADDRESS 4900 Belair Road | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/23/65 | | 24C. NAME OF CEMETERY or CREMATORY St. Stanislaus | |
| 24D. LOCATION Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 21 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR M.F. SADOWSKI & SONS, 1808 EASTERN AVE | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9685 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9685 | |
| M.E. CASE NO. | | | 1. NAME OF DECEASED (Type or Print) Wilson, Jerome L., Jr. | | |
| 2. DATE AND HOUR OF DEATH 19 September 1965 12 35 pm M. | | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Lincoln Memorial Nursing Home | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 15-38 | | |
| 5. SEX Male | | | 6. RACE Negro | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widower | | | 8. DATE OF BIRTH Oct 12, 1915 | | |
| 9. AGE (In years lost birthday) 89 | | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITER - Retired | | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Jerome L. Wilson, Sr. | | | 14. MOTHER'S MAIDEN NAME Laura A. Goggins | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 212-12-6175 | | |
| 17. INFORMANT Alice C. Rusk-2415 Montebello Terrace 21214 | | | ADDRESS | | |
| 18. 334 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) Bt. Hemiplegia (B) arterial hypertension (C) | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No) | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 2 1965 to Sept 19 1965, that (I) (we) last saw the deceased alive on 9-19 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | 23A. SIGNATURE Mr. Johnson M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/> | | |
| 23B. DATE SIGNED 9-19-65 | | | 23C. PHYSICIAN'S NAME (Type) Dr. Johnson M.D. | | |
| 23D. ADDRESS 403 Md. Arts Bldg | | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | |
| 24B. DATE 9/22/65 | | | 24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park | | |
| 24D. LOCATION (City, town, or county) (State) Arbutus, Maryland | | | 25A. DATE REC'D BY HEALTH DEPT. SEP 21 1965 | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | | 25C. FUNERAL DIRECTOR ADDRESS EDGAR L. LYNCH, 2463 Druid Hill Ave-21217 | | |

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BALTIMORE CITY HEALTH DEPARTMENT

65 9686

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

THOMAS W. RYLAND

2. DATE AND HOUR PRONOUNCED DEAD

9/19/65 2:46 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

33

Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6023 Gwynn Oak Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

June 9, 1944

9. AGE (In years
last birthday)

21

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Mechanic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Cumberland, Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William F. Ryland

14. MOTHER'S MAIDEN NAME

Doris E. McDermott

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

Yes

17. INFORMANT

ADDRESS

James A. Ryland 5202 Gwynndale Avenue

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Overdose of narcotics
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST,

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

?

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)

?

00-00

21D. TIME OF INJURY
(APPROX.)

9 19 65 ?

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

apparent self administration of morphine

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/19/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/22/65

23C. NAME OF CEMETERY or CREMATORY

St. Patricks Cemetery

23D. LOCATION

(City, town, or county)

Cumberland, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

SEP 21 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Ellsworth Armacost

ADDRESS

Ellsworth Armacost 4600 Liberty Heights

WALLER 10 PAGE

FUNERAL DIRECTOR: IMPORTANT

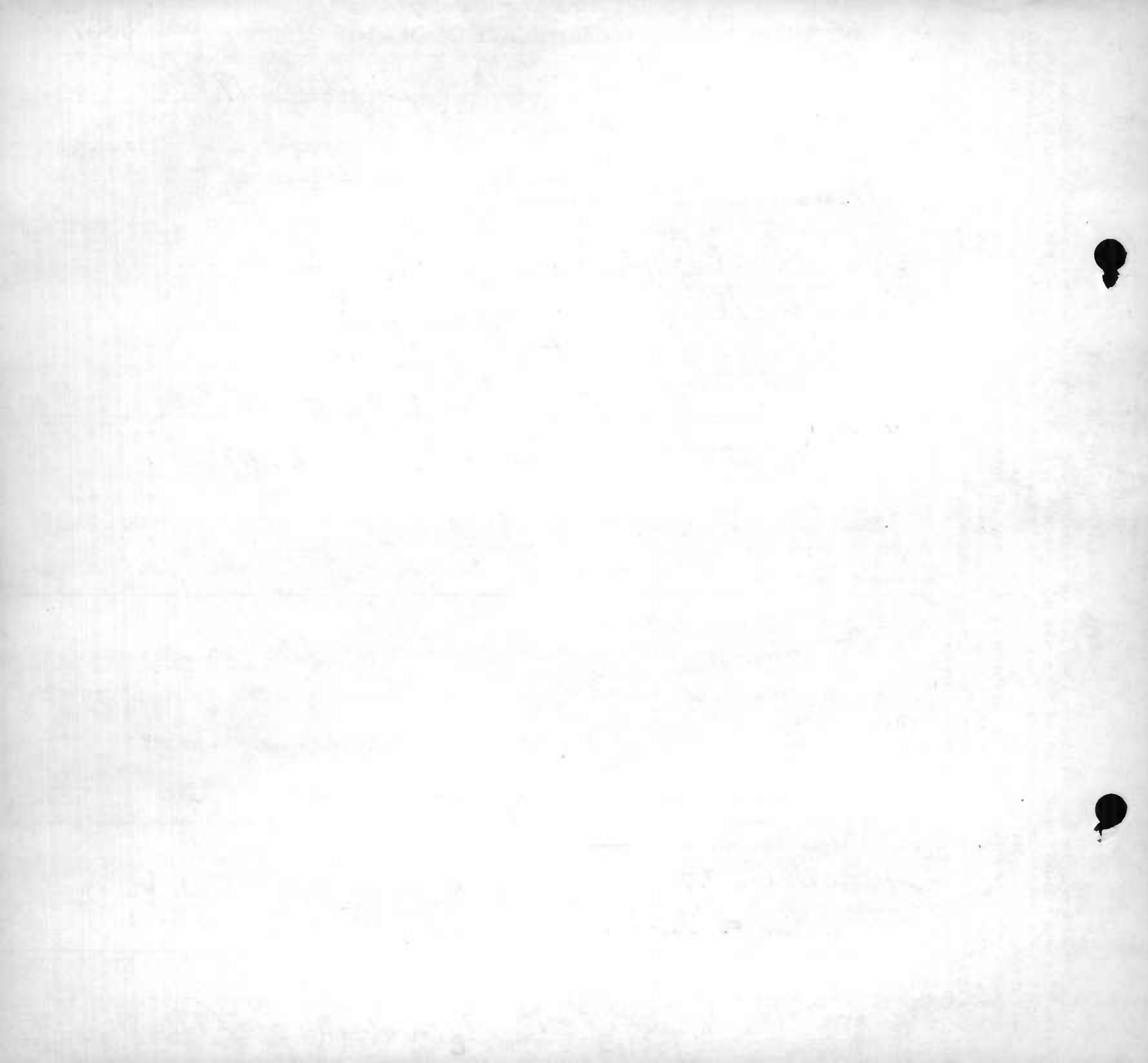
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. **65 9687**

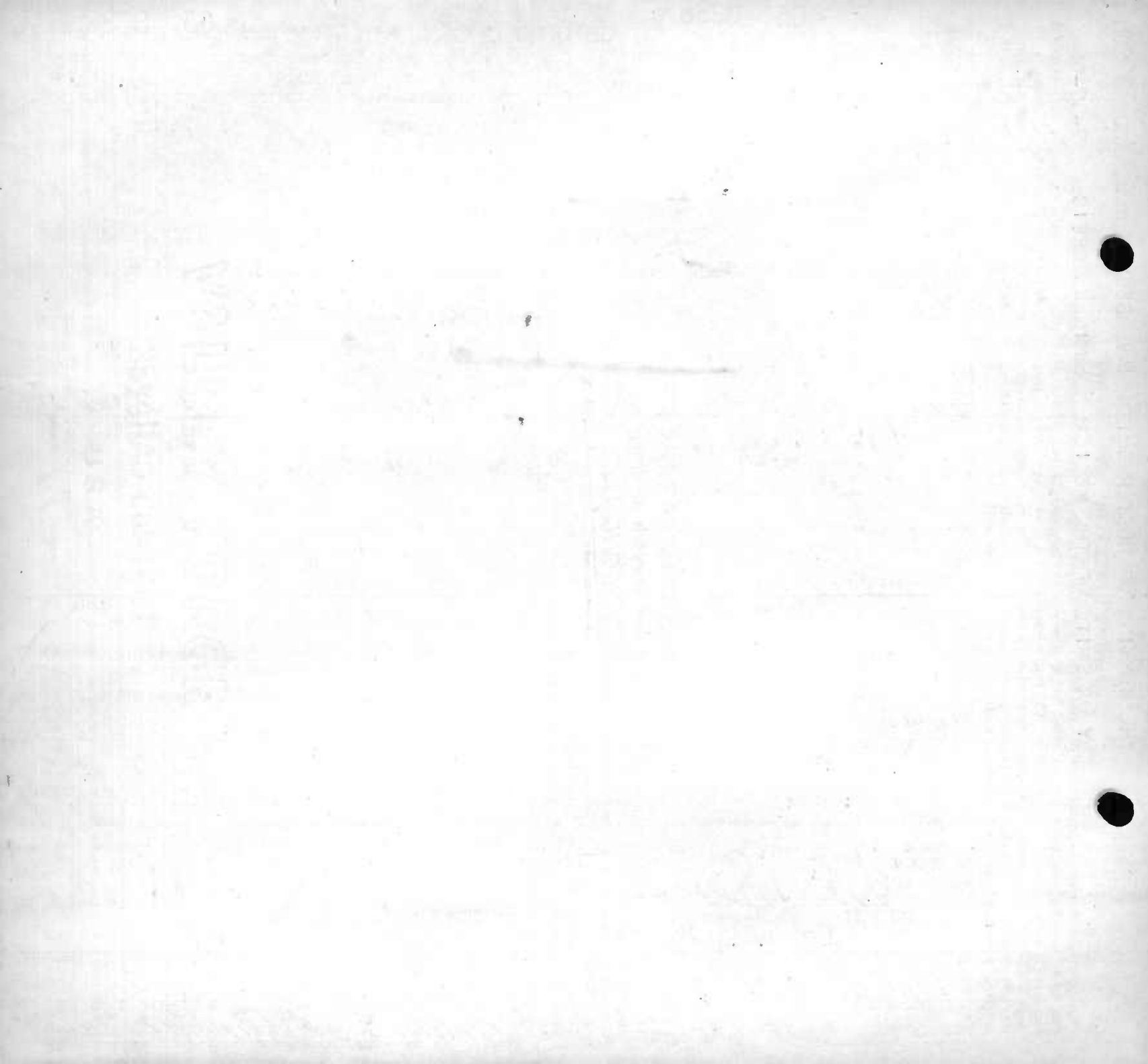
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| BIRTH NO. 65 9687 | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) James Pratt | | 2. DATE AND HOUR OF DEATH Sept 16 - 1965 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY 15-01 | |
| FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| | | D. STREET ADDRESS (If rural, give location) 715 Baker St | |
| 5. SEX Female | 6. RACE Colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH 1884 |
| 9. AGE (In years last birthday) 81 | | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) ? | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME George S. Pratt | | 14. MOTHER'S MAIDEN NAME ? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Joseph Pratt 715 Baker St |
| 18. 430.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Acute Congestive Heart Failure | | INTERVAL BETWEEN ONSET AND DEATH 2 years | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | (B) Generalized Arteriosclerosis 3 years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) No |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from July 1963 to Sept 18 1965 , that (I) (we) last saw the deceased alive on Sept 15 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death. | | | |
| 23A. SIGNATURE Semin H. Cartoy | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | 23B. DATE SIGNED 20 Sept 65 |
| 23C. PHYSICIAN'S NAME (Type) Semin H. Cartoy | | 23D. ADDRESS 1277 Aurora A. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE Sept 23/65 | 24C. NAME of CEMETERY or CREMATORY Pleasant Rest | 24D. LOCATION Md (City, town, or county) (State) |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 21/1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor M.D. | 25C. FUNERAL DIRECTOR W. Brooks Ruggold |
| | | ADDRESS 1463 N. Carey St | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner of the Baltimore City Health Department. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 5-30 65 9688 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9688 | |
| M.E. CASE NO. | | | 1. NAME OF DECEASED (Type or Print) BUSTER SMITH | | |
| 2. DATE AND HOUR OF DEATH 9-17-65 7:54 P.M. | | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 7-04 | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | |
| D. STREET ADDRESS (If rural, give location) 922 NORTH BOND STREET | | | 5. SEX MALE | | |
| 6. RACE NEGRO | | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | | |
| 8. DATE OF BIRTH 3-11-12 | | | 9. AGE (In years last birthday) 53 | | |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | 11. BIRTHPLACE (State or foreign country) Rutherfordton N.C. | | |
| 12. CITIZEN OF WHAT COUNTRY? | | | 13. FATHER'S NAME ASBURY SMITH | | |
| 14. MOTHER'S MAIDEN NAME IDA HAROLD | | | 15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service) yes World War II | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT Novella Smith 922 N. Bond St. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Rheumatic Heart Disease | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | 20. CAUSE OF DEATH Rheumatic Heart Disease | | |
| 21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | 22. I certify that (I) (this hospital) attended the deceased from 19 to 19 65, that (I) (we) last saw the deceased alive on 9-17-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | |
| 23A. SIGNATURE Lee J. Silver | | | 23B. DATE SIGNED 9/17/65 | | |
| 23C. PHYSICIAN'S NAME (Type) LEE J. SILVER | | | 23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE Sept 21/65 | | |
| 24C. NAME OF CEMETERY or CREMATORY Balt. Natl. Cem. | | | 24D. LOCATION (City, town, or county) (State) 5501 Fredrick Ave. | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 21 1965 | | | 25B. NAME OF REGISTRAR Robert E. Farkner | | |
| 25C. FUNERAL DIRECTOR Milton E. Elchman | | | 25D. ADDRESS 1129 N. Carroll St | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9689 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 9689 | |
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| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Newell, Robert Clifford, Sr. | | | | 2. DATE AND HOUR OF DEATH Sept-20-'65 7:10 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital Baltimore, Maryland | | | | A. STATE Baltimore, Maryland B. COUNTY | | | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 1527 Northgate Rd. Baltimore Md. | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH 9/8/94 | 9. AGE (In years lost birthday) 71 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Manager - Acme Market | | | 10B. KIND OF BUSINESS OR INDUSTRY Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Charles A. Newell | | | | 14. MOTHER'S MAIDEN NAME Clara Stauffer | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WWI | | | 16. SOCIAL SECURITY NO. WWI | | 17. INFORMANT MARIE A. Newell | | ADDRESS Same |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH H51X I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH Ruptured aortic aneurysm | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | | (C) Phr. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION Sept-6-1965 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured abdominal aorta | | 19A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) // | | 21C. WHERE DID INJURY OCCUR? // | | (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) // | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? // | | | |
| 22. I certify that (1) (this hospital) attended the deceased from Sept-6-1965 to Sept. 20 1965 , that (1) (we) lost saw the deceased alive on Sept. 20 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Kang Fan | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Sept-20-65 | |
| 23C. PHYSICIAN'S NAME (Type) KANG FAN | | | | 23D. ADDRESS Union Memorial Hospital 33rd & Calvert Street | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/23/65 | | 24C. NAME OF CEMETERY or CREMATORY BALTIMORE NATIONAL | | 24D. LOCATION (City, town or county) BALTIMORE Md | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 21 1965 | | 25B. NAME OF REGISTRAR Robert E. Fink | | 25C. FUNERAL DIRECTOR LEONARD J. RUCK, INC | | ADDRESS BALTIMORE, Md | |

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)KATHERINE ^{Mary} BUCHWALD

2. DATE AND HOUR PRONOUNCED DEAD

9/20/65 11:20 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 6

D. STREET ADDRESS (If rural, give location)

6200 Commons Rd.

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

widowed

8. DATE OF BIRTH

April 12, 1907

9. AGE (In years
last birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

John Scheckles

14. MOTHER'S MAIDEN NAME

Not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

216309227

17. INFORMANT

John Buchwald

ADDRESS

same

18. 002.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

Pulmonary tuberculosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/21/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

burial

23B. DATE

9-24-65

23C. NAME of CEMETERY or CREMATORY

Baltimore Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

SEP 21 1965

24B. NAME OF REGISTRAR

Robert E. Fidler, M.D.

24C. FUNERAL DIRECTOR

Leonard J. Ruck Inc Baltimore, Md.

ADDRESS

VALLEY FORGE

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.1. NAME OF DECEASED
(Type or Print)

BLANCHE TAYLOR

2. DATE AND HOUR PRONOUNCED DEAD

September 19, 1965 1:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

ST. JOSEPH HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1906 E. Lanvale Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Aug 30 1916

9. AGE (In years
last birthday)

49

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Fairfield County S.C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Jordan Foster

14. MOTHER'S MAIDEN NAME

Mattie Gladney

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown. If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Isaac Taylor 1906 E. Lanvale St

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Pulmonary embolism
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

R S Fisher

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9-20-65

EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

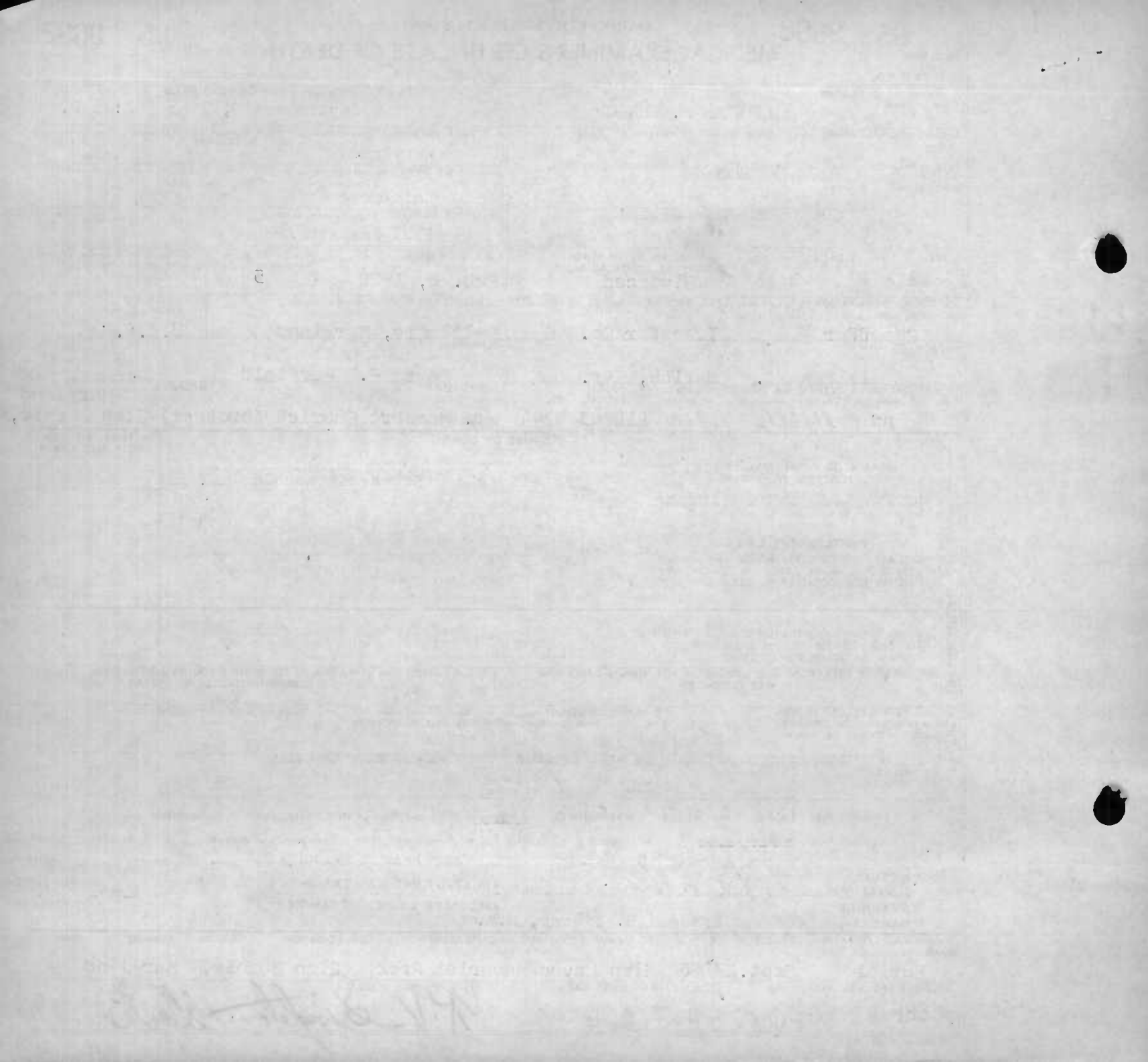
SEP 21 1965

Robert E. Fisher, M.D.

Joseph T. Elickson 1129 N. Carroll St

WALLER PAPER

MADE IN U.S.A.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | BIRTH NO. 65 9693 | | CERTIFICATE OF DEATH | | Registered No. 65 9693 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------|-----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|---------------------------------------------------------------------------------|--|---------------------------------------------------|--|
| 1. NAME OF DECEASED (Type or Print) AMANDA BELCHER | | | | 2. DATE AND HOUR OF DEATH 9-18-65 12.10 A.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 26-34 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1001 SPANGLER WAY | | | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 10-10-85 | 9. AGE (In years last birthday) 79 | If Under 1 Yr. Months: Days: Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) Welch, W. Va. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME JASPER GREEN | | | 14. MOTHER'S MAIDEN NAME LIZA GROSS | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. --- | | 17. INFORMANT Cecil C. Belcher, Street, Md. | | | | |
| 18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) (C) Middle cerebral artery thrombosis | | | | CAUSE OF DEATH (A) DUE TO ASCVD (B) DUE TO (C) DUE TO | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None | | | | | | | | | |
| 19A. DATE OF OPERATION 9-18-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-15 19 65 to 9-18 19 65 , that (I) was last saw the deceased alive on 9-18 19 65 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) Was (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Nicholas J. Fortuin | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-18-65 | | | |
| 23C. PHYSICIAN'S NAME (Type) NICHOLAS J. FORTUIN | | | | 23D. ADDRESS JOHNS HOPKINS HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-20-65 | | 24C. NAME of CEMETERY or CREMATORY Dublin Southern | | 24D. LOCATION (City, town, or county) (State) Dublin Street, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 22 1965 | | 25B. NAME OF REGISTRAR Robert E. Fortuin | | 25C. FUNERAL DIRECTOR John H. Harkins | | ADDRESS Delta, Penna. | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

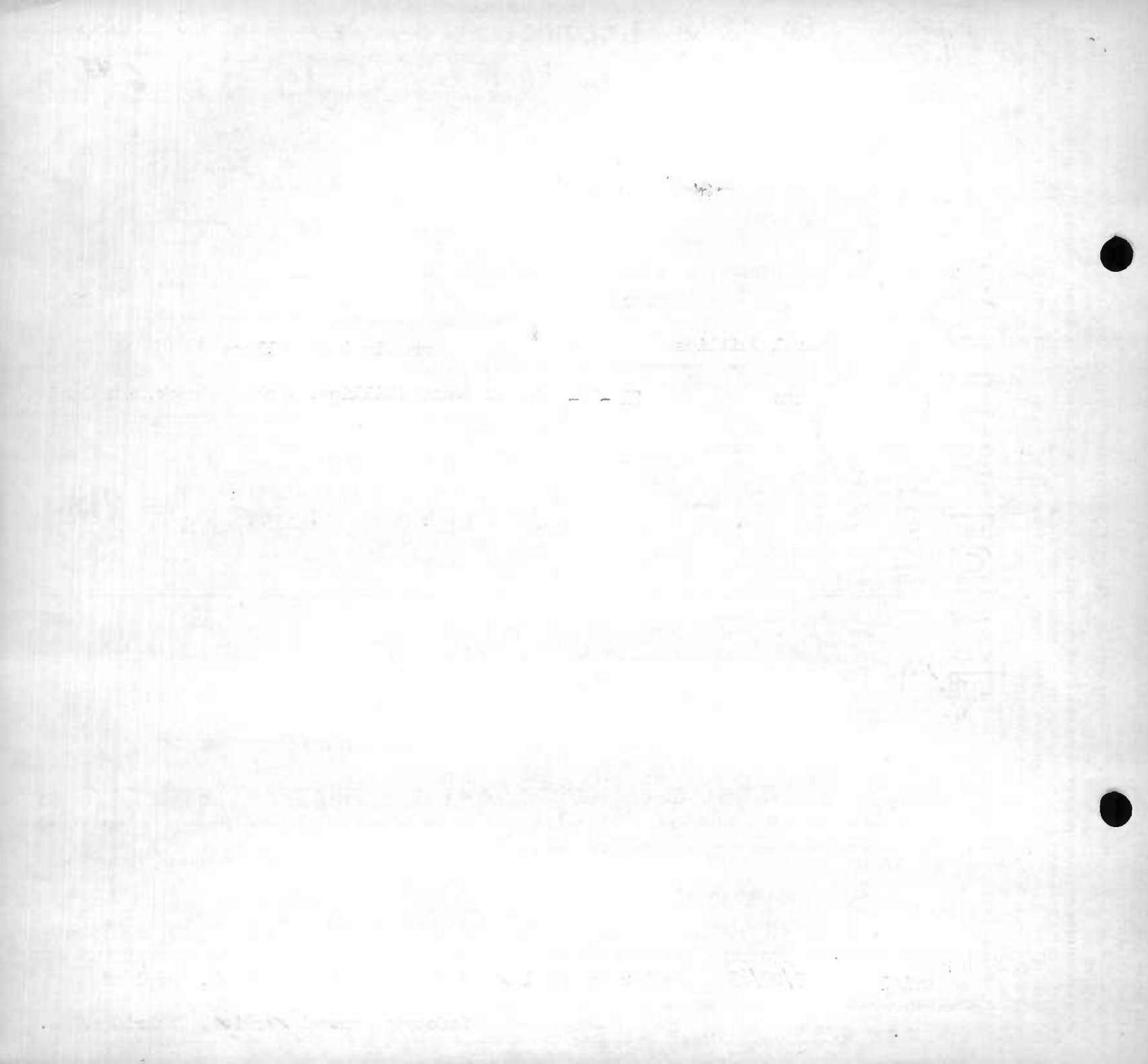
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9694 | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. 65 9694 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Welch, Ellen Elizabeth (Mrs.)</i> | | 2. DATE AND HOUR OF DEATH <i>9/18/65 2:12 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE <i>Maryland</i> B. COUNTY <i>Harford</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>44 The Union Memorial Hospital</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Cardiff 62-00</i> | | D. STREET ADDRESS (If rural, give location) <i>None</i> | |
| 5. SEX <i>Female</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Widow</i> | 8. DATE OF BIRTH <i>8/27/86</i> | 9. AGE (In years last birthday) <i>79</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>Griffith</i> | | 14. MOTHER'S MAIDEN NAME <i>Susan Krick</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>217-52-844</i> | | 17. INFORMANT (same as above) <i>Mrs. Oleta Glackin (Charles)</i> | |
| 18. <i>443X-2903.4</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the made of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 19. CAUSE OF DEATH <i>Congestive Heart Failure Cardiac Arrest H.C.V.D. + A.S.C.V.D. Fracture, Closed, R Hip Diabetes mellitus</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>1 day ? 3 days</i> | |
| 19A. DATE OF OPERATION <i>9/17/65</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Fractured Hip</i> | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg. etc.) <i>Home</i> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>Cardiff, Maryland</i> | |
| 21D. TIME OF INJURY (APPROX.) <i>9/15/65 8PM</i> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <i>Fall in Living Room</i> | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9/16</i> 19 <i>65</i> to <i>9/18</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>9/18</i> 19 <i>65</i> and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>A.C. Tipton, Jr.</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>9/18/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>A. C. TIPTON JR</i> | | 23D. ADDRESS <i>The Union Memorial Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>9-21-65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>ST. MARYS</i> | |
| 24D. LOCATION <i>PYLESVILLE, Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 22 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Farley</i> | |
| 25C. FUNERAL DIRECTOR <i>John H. Halpin</i> | | ADDRESS <i>DELTA, Pa.</i> | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

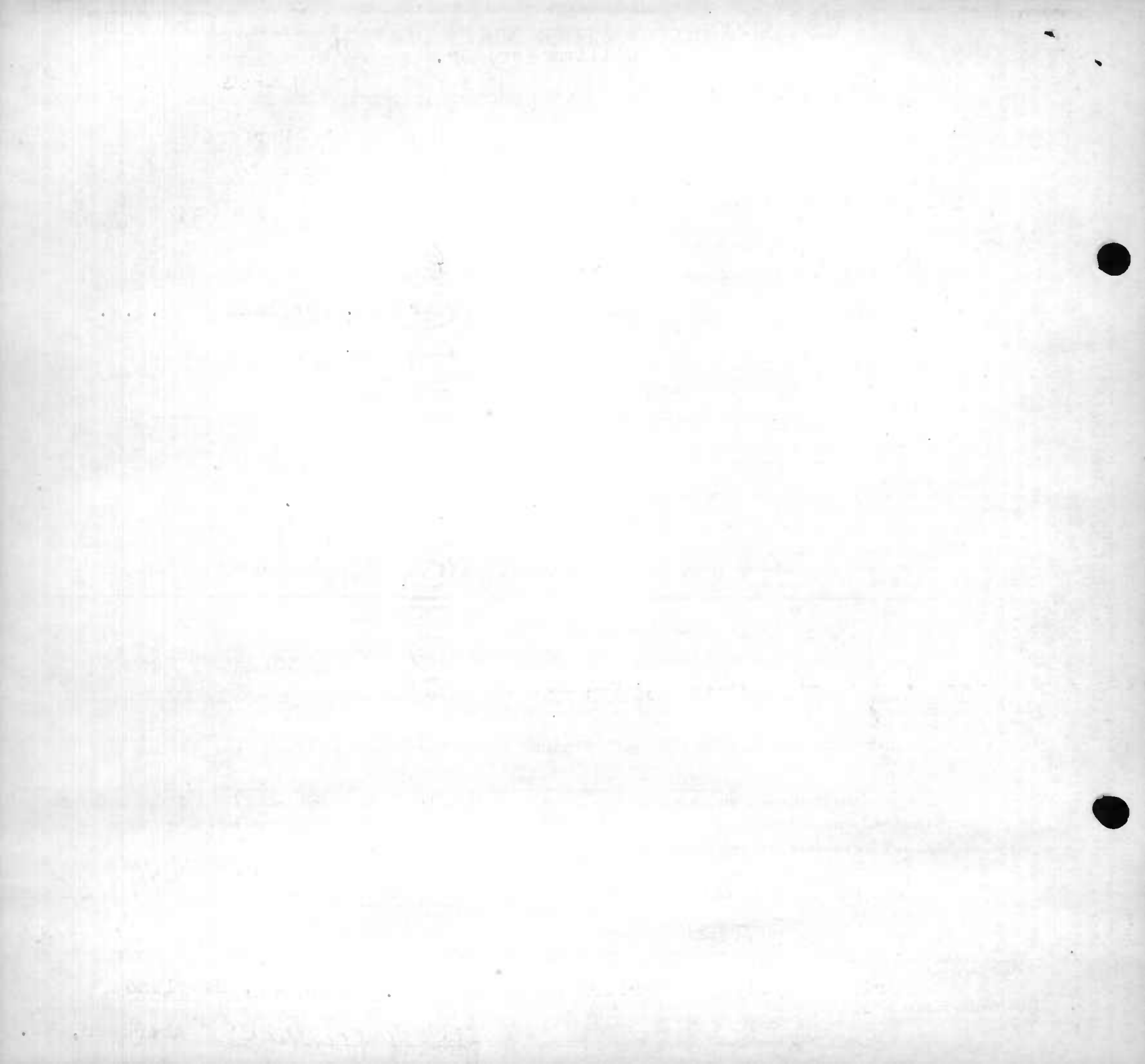
| | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------|--|
| BIRTH NO. 65 9695 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9695 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | 1. NAME OF DECEASED (Type or Print) <i>Charles William Phillips</i> | |
| 2. DATE AND HOUR OF DEATH <i>9-18-65 6:45 A.M.</i> | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>UNIV of MD. HOSPITAL</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>FISHING CREEK</i> | | | |
| 5. SEX <i>M</i> | | 6. RACE <i>W</i> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>W</i> | |
| 8. DATE OF BIRTH <i>9-28-77</i> | | 9. AGE (In years last birthday) <i>77</i> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>WATERMAN</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>MD., LISA</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>YES USA</i> | | 13. FATHER'S NAME <i>Samuel Phillips</i> | |
| 14. MOTHER'S MAIDEN NAME <i>Emma Virginia Wallace</i> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>218-16-5090</i> | |
| 17. INFORMANT <i>Mr Henry Phillips, Fishing Creek, Maryland</i> | | 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) <i>SUBDURAL HYPOTONIA & HEMORRAGIC INFARCTION OF TEMPORAL LOBE</i> | | <i>2 WKS.</i> | |
| ANTECEDENT CAUSES | | (B) <i>TEMPORAL LOBE</i> | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>9-17-65</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>SUBDURAL HYPOTONIA</i> | | 20A. AUTOPSY? (Yes or No) <i>NO</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9-17-65</i> to <i>9-18-65</i> , that (I) (we) last saw the deceased alive on <i>9-18-65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Jon Gulbrandson</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>9-18-65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Jon Gulbrandson</i> | | 23D. ADDRESS <i>UNIV of MD. HOSPITAL</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>9/20/65</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Hosier Memorial Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Fishing Creek, Maryland</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 22 1965</i> | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR <i>LeCompte Funeral Service, Cambridge, Md.</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

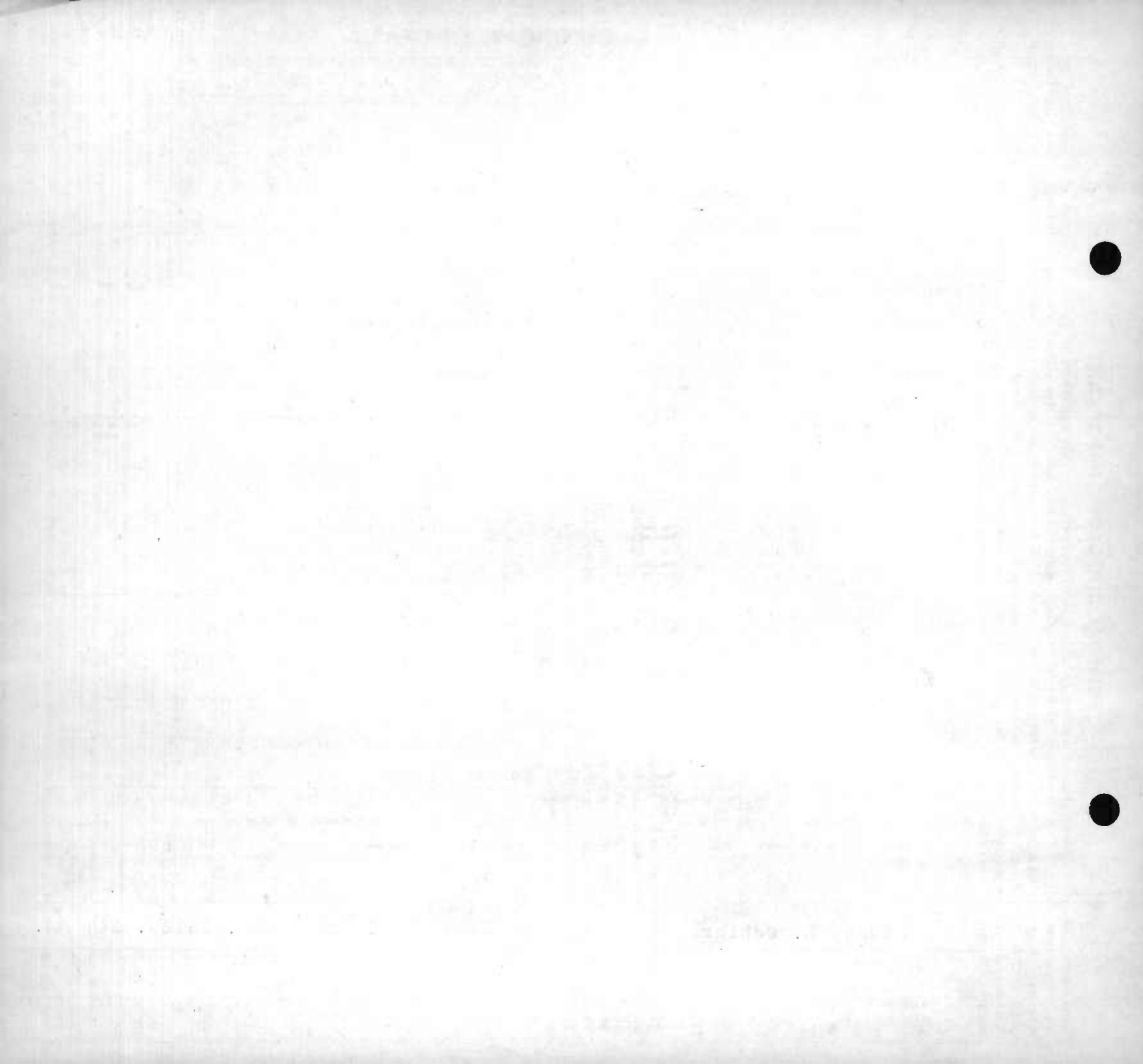
| Baltimore City Health Department | | | | Registered No. 65 9696 | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------|--|
| BIRTH NO. 65 9696 | | CERTIFICATE OF DEATH | | WILLIAM EARL JR. | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MEADOWS | | 2. DATE AND HOUR OF DEATH 9-19-65 11:16 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | A. STATE MD. B. COUNTY Harford | |
| FULL NAME OF HOSPITAL OR INSTITUTION 381 W. of Md. Hospital | | (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) ABERDEEN 62-28 | |
| D. STREET ADDRESS (If rural, give location) 151 DARLINGTON AVE | | 5. SEX M | | 6. RACE W | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE | | 8. DATE OF BIRTH 9-6-65 | | 9. AGE (In years lost birthday) 13 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10B. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Harford Co. Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME EARL MEADOWS | | 14. MOTHER'S MAIDEN NAME LUDY CHILDRESS | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. - | | 17. INFORMANT MOTHER ADDRESS | |
| 18. 757.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) DUE TO Respiratory Arrest | | INTERVAL BETWEEN ONSET AND DEATH 15 min | |
| ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) | | (B) DUE TO Hyponatremia | | 13 day | |
| | | (C) Meningo-myeloma | | 13 day | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 9-14-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Meningo-myeloma | | 20A. AUTOPSY? (Yes or No) no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-9-65 to 9-19-65, that (I) (we) last saw the deceased alive on 9-19-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Ivan L. Butler | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/19/65 | |
| 23C. PHYSICIAN'S NAME (Type) IVAN L. BUTLER | | M.D. ADDRESS UNIVERSITY HOSP. BALTIMORE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/21/65 | | 24C. NAME OF CEMETERY or CREMATORY Harford Memorial Gdns. | |
| 24D. LOCATION (City, town, or county) Aberdeen, Maryland | | 24E. STATE (State) Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 22 1965 | | 25B. NAME OF REGISTRAR Robert E. Finkbeiner | | 25C. FUNERAL DIRECTOR ADDRESS William W. Wynn, Jr. Parring Funeral Home | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|--------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 65 9697 | | CERTIFICATE OF DEATH | | 65 9697 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>John B. Jeck</i> | | 2. DATE AND HOUR OF DEATH <i>9-17-65 6:15 PM</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>43 So. Baito. Gen.</i> | | A. STATE <i>MD.</i> B. COUNTY <i>AA-52-00</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Brooklyn</i> | |
| | | D. STREET ADDRESS (If rural, give location) <i>10 Jewell Ave</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>M.</i> | 8. DATE OF BIRTH <i>4-23-15</i> | 9. AGE (In years last birthday) <i>50</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>TECH.</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>U.S.C.G.</i> | | 11. BIRTHPLACE (State or foreign country) <i>02 Md.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME <i>Chas. D.</i> | | 14. MOTHER'S MAIDEN NAME <i>Berna A. Preston</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <i>Family - SAME</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>420.1 I</i> | | CAUSE OF DEATH (A) <i>Crowning Thrombosis</i> DUE TO (B) <i>Arteriosclerotic C.V. & Hypertension</i> DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i> <i>3 year</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>3/22</i> 19 <i>63</i> to <i>Sep 17</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>7/6</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Sidney R. Gehlert</i> | | | | 23B. DATE SIGNED <i>9/20/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Sidney R. Gehlert</i> | | 23D. ADDRESS M.D. <i>4700 Pennington Ave. Balto. 26, Md.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <i>9/21/65</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Meadowdale</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 22 1965</i> | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Farley</i> | | 25C. FUNERAL DIRECTOR <i>McC (214) 30 E. Tow Co.</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9698 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9698 | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|-----------------------------------------------------------------------------------------------------------|-----------------------------------|----------------------------------------------------------------------------------------------|-----------------------------------------------------------|----------------------------------------------------------------------------|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | M. | |
| 1. NAME OF DECEASED (Type or Print) HYMAN S. Schectter | | | | 2. DATE AND HOUR OF DEATH 4:20 AM 9-19-65 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital of Baltimore Inc 42 Belvedere and Greenspring Ave Balto 15, Maryland. | | | | A. STATE B. COUNTY Maryland Baltimore | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | | D. STREET ADDRESS (If rural, give location) 2305 Tioga Pkwy #15 | | | |
| 5. SEX Male | 6. RACE Caucasian | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 2-7-98 | 9. AGE (In years lost birthday) 67 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fur Salesman | | 10B. KIND OF BUSINESS OR INDUSTRY Fur Salesman | | 11. BIRTHPLACE (State or foreign country) Russia | | 12. CITIZEN OF WHAT COUNTRY? United States | |
| 13. FATHER'S NAME Information not available. | | | | 14. MOTHER'S MAIDEN NAME Information not available | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown | | 16. SOCIAL SECURITY NO. unknown | | 17. INFORMANT ADDRESS Admission Record Sinai Hospital See #3 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction | | | | INTERVAL BETWEEN ONSET AND DEATH 11 days | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Cardiovascular Disease 30 yrs. | | | | (B) DUE TO Arteriosclerotic Cardiovascular Disease 30 yrs. | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None | | | | (C) DUE TO | | | |
| 19A. DATE OF OPERATION None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 9-8-1965 to 9-19-1965 , that (1) (we) lost the deceased on 9-19-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Stanley Leonard Blum M.D. | | | | 23B. DATE SIGNED 9-19-65 | | 23C. PHYSICIAN'S NAME (Type) STANLEY LEONARD BLUM M.D. | |
| 23D. ADDRESS Sinai Hospital of Balto See #3 | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/20/65 | | 24C. NAME OF CEMETERY or CREMATORY HEBREW FRIENDSHIP | | 24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 22 1965 | | 25B. NAME OF REGISTRAR Robert P. Johnson | | 25C. FUNERAL DIRECTOR & ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | | | |

Handwritten text, mostly illegible due to extreme fading and bleed-through from the reverse side of the page. The text appears to be organized into sections, possibly a list or a series of notes. Some legible fragments include:

- Top section: "The following information..."
- Middle section: "The following information..."
- Bottom section: "The following information..."

The document is heavily faded and contains significant bleed-through from the reverse side, making the original content nearly impossible to discern.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9699 | |
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| BIRTH NO. 65 9699 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Barber, Abraham | | 2. DATE AND HOUR OF DEATH 9/19/65 1 10 AM M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital of Baltimore | | A. STATE MD 8. COUNTY 15-13 | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 2619 Park Heights Terrace | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 8/7/08 | 9. AGE in years (last birthday) 57 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | 10B. KIND OF BUSINESS OR INDUSTRY furniture | 11. BIRTHPLACE (State or foreign country) Baltimore, Md | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Isaac L. Barber | | 14. MOTHER'S MAIDEN NAME Late Esther Lieberman | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mrs Harriett Barber - 2619 Park Heights Terrace | |
| 18. 416 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Pulmonary embolism DUE TO (B) Rheumatic heart disease DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH hours 7 25 years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/27 19 65 to 9/19 19 65 , that (I) (we) last saw the deceased alive on 9/19 19 65 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Harry Tabor | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/19/65 | |
| 23C. PHYSICIAN'S NAME (Type) HARRY TABOR | | 23D. ADDRESS M.D. SINAI HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Sept 20/65 | | 24C. NAME of CEMETERY or CREMATORY Hebrew Young Men | |
| 24D. LOCATION (City, town, or county) (State) Woodlawn, Md | | 25A. DATE REC'D BY HEALTH DEPT. SEP 22 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Tabor | | 25C. FUNERAL DIRECTOR ADDRESS Sal Tabor & Sons Inc - 6010 Reest. Rd | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9700 | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-------------------------------------------------------------------------------------------------------------------|---------------------------|--------------------------------------------------------------------------|----------------------------------------------|
| BIRTH NO. 65 9700 | | CERTIFICATE OF DEATH | | Registered No. 65 9700 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Sternberg, Harry | | 2. DATE AND HOUR OF DEATH 9-19-65 2:45 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE MARYLAND B. COUNTY BALTIMORE | | C. CITY OR TOWN BALTIMORE | |
| SINAI HOSP OF BALTIMORE 42 | | D. STREET ADDRESS (If rural, give location) | | 3815 FAIRVIEW AVE | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED | 8. DATE OF BIRTH 11/29/01 | 9. AGE (In years last birth) 63 | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUREAUCRAT | | 10B. KIND OF BUSINESS OR INDUSTRY GOVERNMENT SOCIAL SECURITY | | 11. BIRTHPLACE (State or foreign country) GERMANY, FRANKFORD | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME UNKNOWN MORITZ STERNBERG | | 14. MOTHER'S MAIDEN NAME UNKNOWN, ALICE | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war, or dates of service) UNKNOWN (YES-WWII) | | 16. SOCIAL SECURITY NO. ? | | 17. INFORMANT ADDRESS HARRY M. WALLEN, MD. 5356 CARRIAGE CT. BALTO., MD. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | (A) CARDIAC ARREST DUE TO | | 25 min | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Acute Myocardial Infarction DUE TO | | ? | |
| | | (C) Arteriosclerosis & coronary thrombosis | | ? | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1:25 AM 9-19-1965 to 2:45 PM 9-19-1965, that (I) (we) last saw the deceased alive on 12:30 PM 9-19-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. DID | | | | | |
| 23A. SIGNATURE Harry M. Wallen M.D. | | 23B. DATE SIGNED 9-19-65 | | 23C. PHYSICIAN'S NAME (Type) HARRY M. WALLEN M.D. | |
| 23D. ADDRESS 5356 CARRIAGE CT. BALTO. 21229 | | 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/22/65 | |
| 24C. NAME of CEMETERY or CREMATORY BALTIMORE NATIONAL | | 24D. LOCATION BALTIMORE MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT. SEP 22 1965 | |
| 25B. NAME OF REGISTRAR Robert E. Falkner | | 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | | 25D. ADDRESS | |

RECEIVED

UNIT HOSP OF THE ARMY
3012 PARKWAY AVE

W. 10000 10/1 18

RECEIVED

UNKNOWN

UNKNOWN

HARRY A. LARSEN
CT 10000 10/1 18

UNKNOWN

UNIT HOSP OF THE ARMY

3012 PARKWAY AVE

RECEIVED

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10000 10/1 18

10000 10/1 18

X

HARRY A. LARSEN

CT 10000 10/1 18

HARRY A. LARSEN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 65 9701 | | CERTIFICATE OF DEATH | | Registered No. 65 9701 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------|----------------------------------------------------------------------|--|
| 1. NAME OF DECEASED (Type or Print) DORA NADICH | | | | 2. DATE AND HOUR OF DEATH SEPTEMBER 20, 1965 9 A. M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3106 SEQUOIA AVENUE | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 15-11 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3106 SEQUOIA AVENUE | | | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH | | 9. AGE (In years lost birthday) 90 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (State or foreign country) RUSSIA | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME ? KAPLAN | | | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. NO | | 17. INFORMANT MRS. HILDA COHEN | | ADDRESS 2504 TANEY ROAD | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Coronary artery Disease many yrs. | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH 1 wk. many yrs. | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II Bronchectasis | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-23 1953 to 9-20 1965 , that (I) was last saw the deceased alive on 9/17 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Stanley R Steinbach M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | | | |
| 23C. PHYSICIAN'S NAME (Type) DR. STANLEY STEINBACH M.D. | | | | 23D. ADDRESS 11 SLADE AVENUE | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/21/65 | | 24C. NAME of CEMETERY or CREMATORY HEBREW FRIENDSHIP | | 24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 22 1965 | | 25B. NAME OF REGISTRAR Robert E. Farber | | 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | | | | | |

[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | 65 9702 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | | 65 9702 | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------|-----------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------|----------------------------------------------------------------------|------------------------------|---------------------------------------|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | | | |
| Abraham Selenkow | | | | Sept. 20, 1965 | | | | 8:40 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | | | |
| Sina Hospital of Balto. | | | | Maryland | | | | 27-20 | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | | |
| | | | | BALTO | | | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | | | |
| | | | | 5829 Western Run Dr. | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years - last birthday) | If Under 1 Yr. Months | If Under 24 Hrs. Days | If Under 24 Hrs. Hours | If Under 24 Hrs. Min. | |
| MALE | WHITE | MARRIED | 10/25/1898 | 66 | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | |
| PROPRIETOR | | | PACKAGE LIQUORS | | RUSSIA | | USA | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| DAVID SELENKOW | | | | RABHEL ? | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| NO | | | 218-32-1896 | | MRS. ROSE SELENKOW 5829 WESTERN RUN DRIVE | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO | | | | Myocardial infarction? | |
| | | | | (B) DUE TO | | | | Arteriosclerotic Cardiovascular Dis.? | |
| | | | | (C) DUE TO | | | | Diabetes Mellitus? | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 0 | | | | NO | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | | | |
| | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 20 19 65 to Sept 20 19 65, that (I) (we) last saw the deceased alive on Sept 20 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | | | |
| H. Gerard Oster | | | | Sept 20, 1965 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | |
| H. Gerard Oster | | | | Sina Hospital | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) | | (State) | |
| BURIAL | | 9/22/65 | | BALTIMORE HEBREW | | REISTERSTOWN, MARYLAND | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | 25B. NAME OF REGISTRAR | | | 25C. FUNERAL DIRECTOR ADDRESS | | | |
| SEP 22 1965 | | | Robert E. Farkner | | | SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | | | |

10127107

WILLIAM

BAGLEY

DAVID BELLER

DAVID BELLER

211-11-1895

10127107

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------------------|
| BIRTH NO. <u>065-25154</u> <u>65</u> <u>9703</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | REGISTERED NO. <u>65</u> <u>9703</u> | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>MC CULLOUGH</u> <u>BABY</u> <u>BOY</u> | | | | | |
| 2. DATE AND HOUR OF DEATH <u>SEPT 20 1965</u> <u>2:30P</u> M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>40 ST AGNES HOSPITAL</u> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>AA</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>GLEN BURNIE</u> D. STREET ADDRESS (If rural, give location) <u>300 GEORGIA AVENUE</u> | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NEVER MARRIED</u> | 8. DATE OF BIRTH <u>9-18-65</u> | 9. AGE (In years last birthday) <u>1</u> | If Under 1 Yr. Months: <u>1</u> Days: <u>17</u> Hours: <u>24</u> Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u> |
| 12. CITIZEN OF WHAT COUNTRY? | | | 13. FATHER'S NAME <u>RAY</u> | | |
| 14. MOTHER'S MAIDEN NAME <u>JACQUELINE MURPHY</u> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT <u>ST AGNES HOSPITAL CATON & WILKENS AVE.</u> | | |
| 18. <u>773.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> <u>Respiratory Distress Syndrome</u> (A) DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> | | | 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>SEPT 18 1965</u> to <u>SEPT 20 1965</u> , that (I) (we) last saw the deceased alive on <u>SEPT 20 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Humberto J. Hernandez</u> | | | | 23B. DATE SIGNED <u>Sept 20, 1965</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>HUMBERTO HERNANDEZ</u> | | | | 23D. ADDRESS <u>St. Agnes Hos. Baltimore Md</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9/21/65</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>Lorraine</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 22 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Fawcett</u> | |
| 25C. FUNERAL DIRECTOR <u>Harry Holmquist</u> | | 25D. ADDRESS <u>4204 Ridgewood Ave Baltimore Md 21208</u> | | | |

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9-19-65
REL. NON MEDDR. SPITZ
Buecker, Ella 117357
Funeral Director: Important

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|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|---------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------|-----------------------------|
| BIRTH NO. 65 9704 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9704 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | X | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| ELLA M. BUECKER | | 9-19-65 | | 11:55 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| 33 THE JOHNSHOPKINS HOSPITAL | | MARYLAND (HARFORD) 62-00 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | STREET | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| Box 111 | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | 10. Under 1 Yr. Months Days |
| FEMALE | WHITE | MARRIED | 2-10-98 | 67 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | Home | | Fawn Grove, Pa. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| FRANK WEBB | | CATHERINE WAMBAUGH | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No --- 213-28-0678 | | Henry L. Buecker | | Street, Maryland | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| I | | (A) DUE TO CVA, thrombotic | | 1 week | |
| ANTECEDENT CAUSES | | (B) DUE TO ASCVD | | 20 yrs. | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | No | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/15/65 19 to 9/19/65 19 that (I) (we) last saw the deceased alive on 9/19/65 19 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| J.R. Spencer | | | | 9/19/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| J.R. SPENCER | | M.D. JOHNS HOPKINS HOSP. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 9/22/1965 | | Jarrettsville | |
| | | | | Jarrettsville Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| SEP 22 1965 Robert E. Taylor | | | | Charles E. Kutz Jarrettsville, Md. | |

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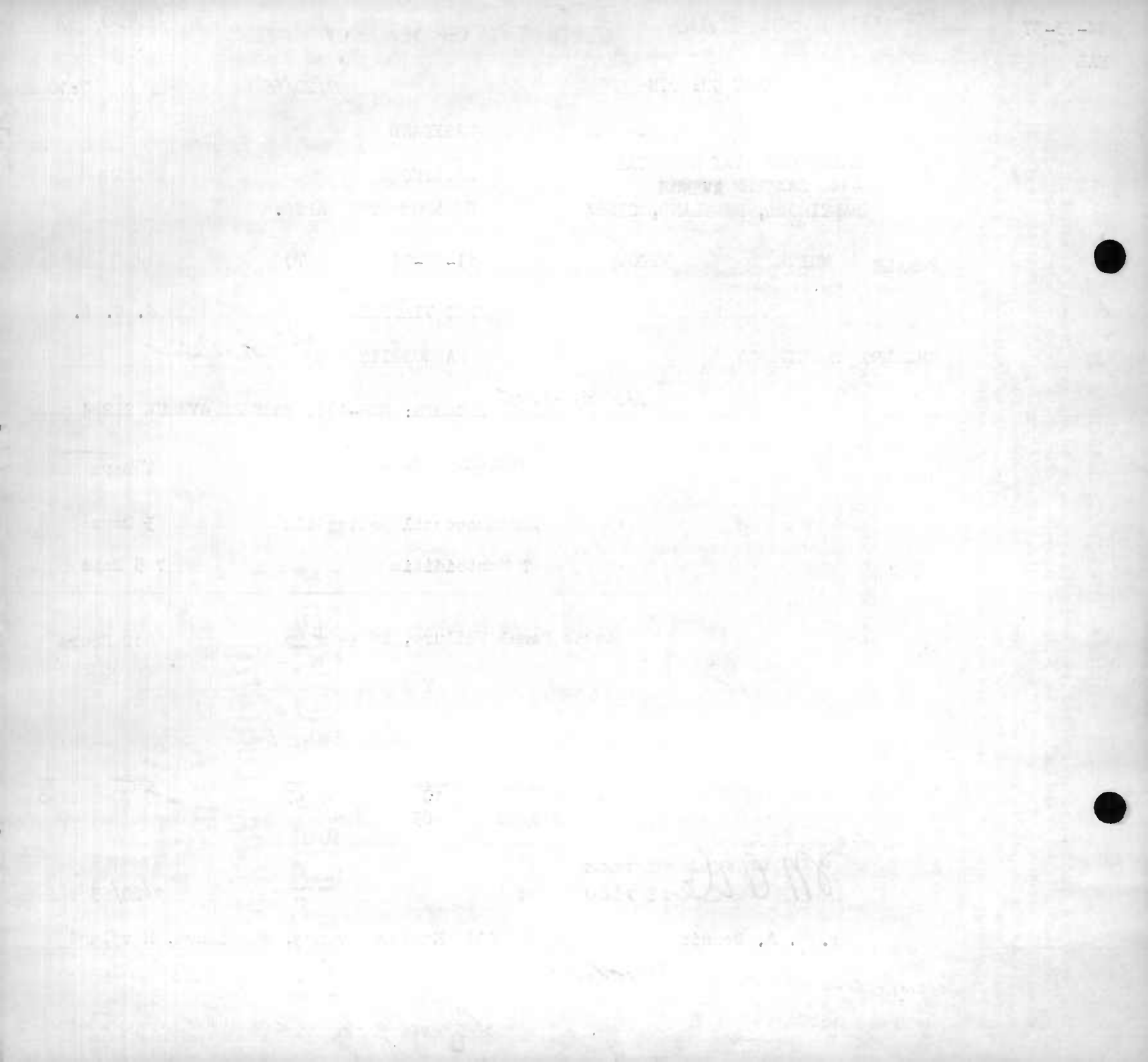
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|--------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------|----------------------------------------------|
| BIRTH NO. 65 9705 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9705 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| MARY GRIFFIN | | 9/20/65 | | 7:10 PM. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| BALTIMORE CITY HOSPITAL | | MARYLAND | | Baltimore | |
| 31 4940 EASTERN AVENUE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | BALTIMORE | |
| BALTIMORE, MARYLAND, 21224 | | D. STREET ADDRESS (If rural, give location) | | 66 EDGEWATER APTS. | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (in years last birthday) | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| FEMALE | WHITE | WIDOW | 11-22-94 | 70 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | WEST VIRGINIA | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| U. S. A. | | CHARLES MONEYPENNY | | MARGUERITE Echols | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | 236-03-0105 | | RECORDS: BCH-4940 EASTERN AVENUE 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET BEFORE DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) Cerebral Edema | | 2 Days | |
| ANTECEDENT CAUSES | | (B) Pneumococcal Meningitis | | 3 Days | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) ? Mastoiditis | | ? 5 Days | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Acute Renal Failure, 2° to ↓ BP | | 12 Hours | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/18 19 65 to 9/20 19 65, that (I) (we) last saw the deceased alive on 9/20 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| Dr. M. A. Dennis | | | | 9/20/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Dr. M. A. Dennis | | 4940 Eastern Avenue, Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial & Removal | | 9/24/65 | | Macdaniel Cemetery | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. FUNERAL DIRECTOR | | 24F. ADDRESS | |
| Heston, N. Va. | | Connolly | | 380 Macdaniel Ave. Balt. 21 | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| SEP 22 1965 | | Robert E. Taylor | | Connolly | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 65 9706 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9706 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MARGARET MAY | | 2. DATE AND HOUR OF DEATH 9-19-65 4:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND, B. COUNTY Balto C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE ESSEX 53-00 D. STREET ADDRESS (If rural, give location) 203 MARGARET AVE. | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 5-10-18 | 9. AGE (In years lost, in day) 47 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Hazelton, Pa. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME HARRY REIMOLD | | 14. MOTHER'S MAIDEN NAME ETHEL POLGREAN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Husband (Same as above) | |
| 18. 43411 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Probable emboli to cerebrum and L leg. | | CAUSE OF DEATH (A) DUE TO CHF, R/O MI (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 2 hours | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from September 1 19 65 to September 19 19 65, that (I) (we) last saw the deceased alive on September 19 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE W Leigh Thompson | | M.D. Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED INTERNE Sept 19, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) W. Leigh Thompson | | 23D. ADDRESS The Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/22/65 | | 24C. NAME OF CEMETERY or CREMATORY Garden of Faith | |
| 24D. LOCATION (City, town, or county) (State) Balto. Co. Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 22 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR Connolly 300 Mace Ave. Balto. 21 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or indirect cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------------------------------------------|----------------------------|------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
| M.E. CASE NO. | | 65 9707 | | 65 9707 | |
| 1. NAME OF DECEASED (Type or Print) | | UHL, EDWARD C. | | 2. DATE AND HOUR OF DEATH 9-20-65 4:55 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital | | D. STREET ADDRESS (If rural, give location) 355-Upperlanding Rd | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Police Dept. (Baltimore) | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 9/6/27 | 9. AGE (In years last birthday) 38 | If Under 1 Year: Months: Days: If Under 24 Hrs.: Hours: Min. |
| 11. BIRTHPLACE (State or foreign country) Balto., Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Edward H. Uhl | |
| 14. MOTHER'S MAIDEN NAME Bessie Westgate | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 220-20-2550 | |
| 17. INFORMANT Wife (Same as above) | | 18. CAUSE OF DEATH (A) DUE TO BRAIN SWELLING (B) DUE TO CEREBRAL INFARCTION (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH 24 hr. 4 days | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 9/19/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PITUITARY TUMOR | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 6 September 1965 to 20 Sept 1965, that (we) last saw the deceased alive on 20 Sept 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Lincoln Jeanes Jr. | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Sept 20, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Lincoln Jeanes Jr. | | 23D. ADDRESS M.O. The Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/23/65 | | 24C. NAME of CEMETERY or CREMATORY Oak Lawn | |
| 24D. LOCATION (City, town, or county) (State) Balto., Co. Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 22 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR Connolly, 300 Mac Ave, Balto. 21 | | ADDRESS | | | |

100-100000

Johns Hopkins University

Miss Alice M. Mearns

Edward A. Mearns

Bessie Mearns

Brain specimen

Cerebral infarction

9/10/02

Specimen of water

as per

Dr. J. Mearns

Specimen of water

Specimen of water

Specimen of water

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

THOMAS C. OGDEN

2. DATE AND HOUR PRONOUNCED DEAD

9/19/65 2:30 a.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

CERTIFICATE AMENDED

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

108 S. 1085 Arlington Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

9/18/92

9. AGE (In years
last birthday)

73

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Machine est

10B. KIND OF BUSINESS OR INDUSTRY

Steel

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

218-46468

17. INFORMANT

ADDRESS

Gladys Ogden 1085 Arlington Ave

18. S.S. 218-18-6468

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Pulmonary fat embolism following fractures

DUE TO of both legs and contusions of body sur-
face

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID
(If in Baltimore City, give exact location)
INJURY OCCUR?

Lombard and Arlington Ave.

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
9 19 65 1:00 a.

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

pedestrian struck by car

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/19/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/22/65

23C. NAME of CEMETERY or CREMATORY

Cedar Hill Cemetery

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

SEP 22 1965

24B. NAME OF REGISTRAR

Robert E. Johnson

24C. FUNERAL DIRECTOR

Walter Funeral Home Pratt & Smith Sts

ADDRESS

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 9709 | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|----------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|---------------------------------------------------------|
| M.E. CASE NO. | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. | | | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR PRONOUNCED DEAD | | |
| Jewell ROBERTA J. BASHOW | | | September 17, 1965 1:15 A.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE Maryland | | |
| 44 Union Memorial Hospital | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 8-06 | | |
| | | | D. STREET ADDRESS (If rural, give location) 1542 N. Broadway | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. UNDER 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| female | white | widowed | 2-19-1928 | 37 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Clerk | | drug store | | West Virginia | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Edward Edwards | | | Leatia Ronk | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| no | | ??? | | Chapman's Fun. Home, Huntington W. Va. | |
| 18. CAUSE OF DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | |
| (A) Asphyxia due to drowning | | | | | |
| DUE TO | | | | | |
| (B) DUE TO | | | | | |
| (C) DUE TO | | | | | |
| II ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | lake | | Lake Montebello 09-02 | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | Driver of auto into lake | |
| 9-16-65 11:18 P.m. | | | | | |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER | | DATE SIGNED | |
| EXAMINER'S NAME (Type) | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | Sept. 17, 1965 | |
| Rudiger Breitenecker, M.D. | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME of CEMETERY or CREMATORY | |
| Burial | | 9-21-65 | | Ronk Cemetery | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR ADDRESS | |
| SEP 22 1965 | | Robert E. Fairbank | | Wm. Cook-Brooks Towson, Inc., Towson 4, Md. | |

Class
Date
New York
New York

University of New York

Department of Education

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | Registered No. 65 9710 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|--------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|------------------------------------|----------------------------------------------------------------------|--|
| BIRTH NO. 65 9710 | | M.E. CASE NO. 65 9710 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) GEORGIA APPLEGARTH SHEEHAN | | | | 2. DATE AND HOUR OF DEATH Sept. 15, 1965 7 P M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital | | (If not in hospital or institution, give street address or location) | | A. STATE Maryland | | B. COUNTY Baltimore -53-00 | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 1705 Edgewood Rd. | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | | 8. DATE OF BIRTH May 28, 1884 | 9. AGE (In years lost birthday) 81 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) not employed | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Llyods, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Thomas Applegarth | | | | 14. MOTHER'S MAIDEN NAME Ada Matilda Bennett | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT ADDRESS Mr. T. Frank Sheehan 621 Charles St. Ave. 21204 | | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION | | | | (A) DUE TO ACVD | | INTERVAL BETWEEN ONSET AND DEATH 2 day 4 yrs. | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 1961 to Sept. 15 1965, that (I) (we) last saw the deceased alive on Sept 14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Joseph F. Li Pira M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED 9-17-65 | | | |
| 23C. PHYSICIAN'S NAME (Type) Joseph F. Li Pira M.D. | | | | 23D. ADDRESS 8400 Loch Raven Blvd, BALTO, 4 Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Sept. 18, 65 | | 24C. NAME OF CEMETERY or CREMATORY Cambridge Cememetry | | 24D. LOCATION (City, town, or county) (State) Cambridge, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 22 1965 | | 25B. NAME OF REGISTRAR Robert E. Farkner | | 25C. FUNERAL DIRECTOR Wm. Cook-Brooks Towson | | ADDRESS 1050 York Rd. Towson, Maryland 21204 | |

ADD MAILING ADDRESS

THANKS AGAIN

NAME

NO

MR. T. FRANK BROWN JR.

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Crate Mailed

Sept 14

X

Joseph F. Li Euer
Joseph F. Li Euer

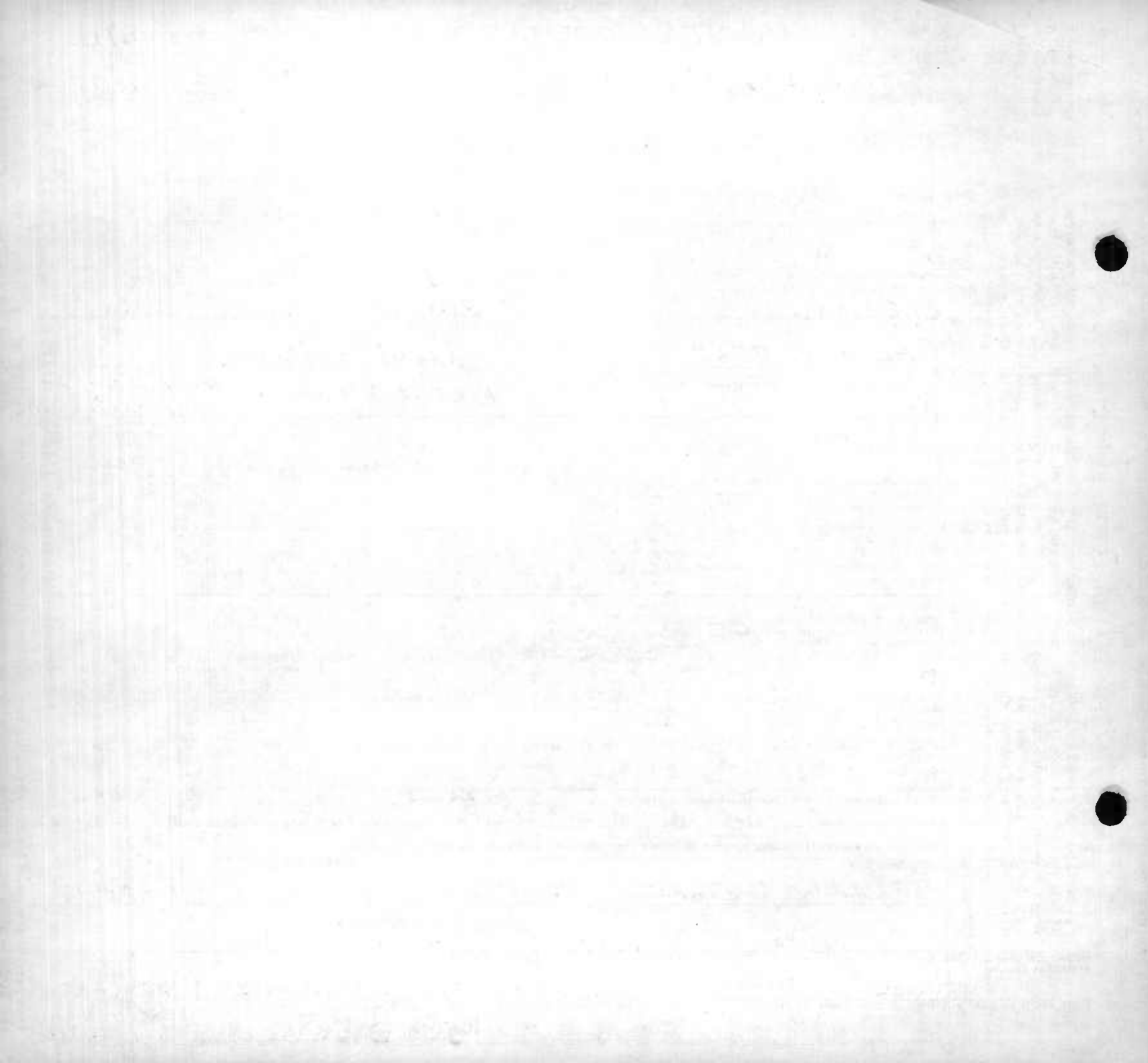
4000 Lakeside Blvd.

9-17-62

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

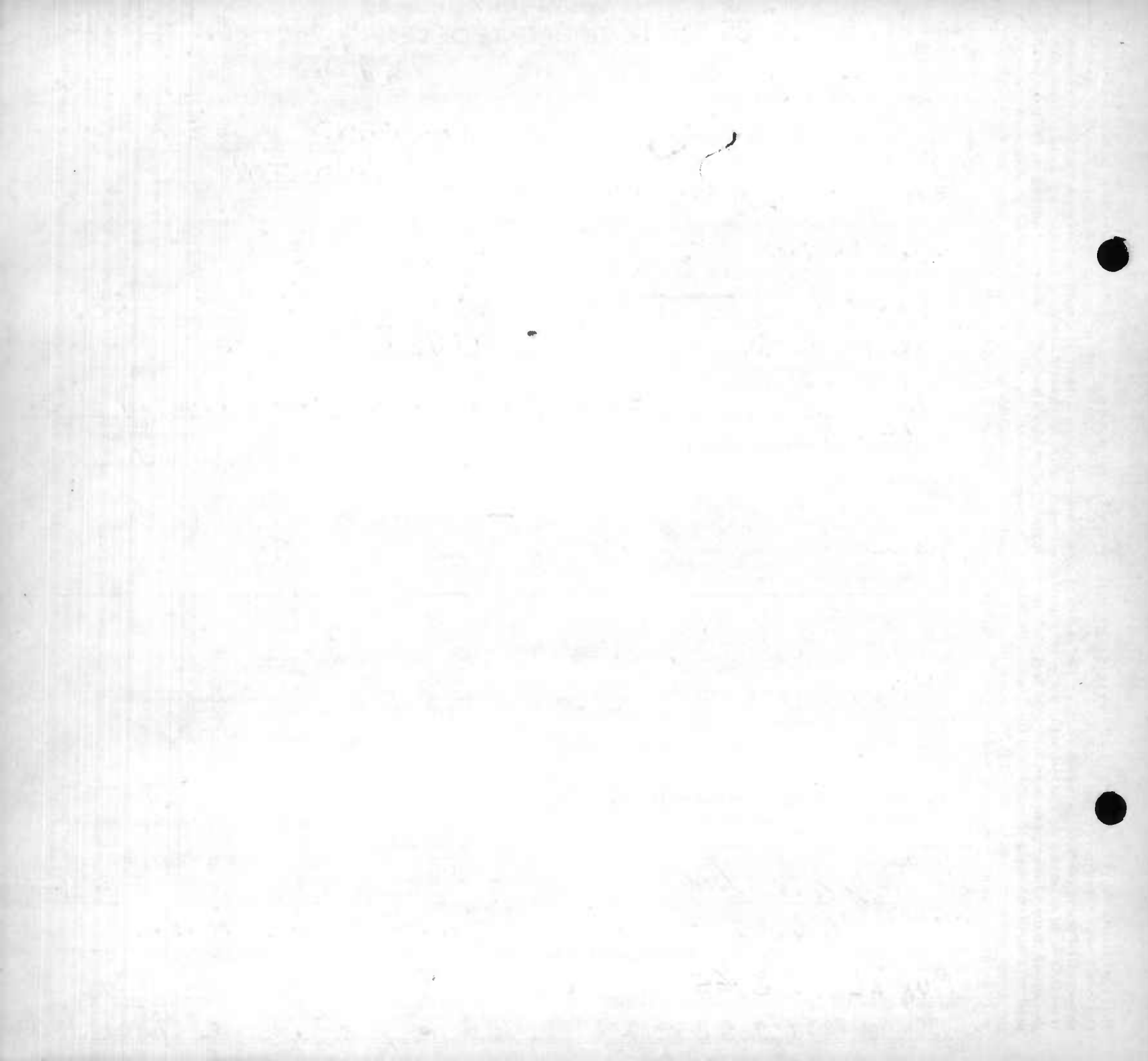
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9711 | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|
| BIRTH NO. 65 9711 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Edna A. Zipprian | | 2. DATE AND HOUR OF DEATH 9-20-65 10:15 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy | | A. STATE Maryland B. COUNTY Baltimore | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) T. Monicum | | | |
| | | D. STREET ADDRESS (If rural, give location) 2117 Reuter Rd. | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 7-20-08 | 9. AGE (In years lost birthday) 57 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHERICAN | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BALTIMORE MD | |
| 13. FATHER'S NAME HUGH N. BELT | | 14. MOTHER'S MAIDEN NAME NAOMI ZEIGLER | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ROBERT G ZIPPRIAN ADDRESS 101 WESLEY DR. SIMPSONVILLE, MD | |
| 18. 199.2.1 | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH I (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) Analogous Carcinomatosis DUE TO | | INTERVAL BETWEEN ONSET AND DEATH years | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) _____ DUE TO | | | |
| | | (C) _____ | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-20-65 19 to 9-20-65 19, that (I) (we) last saw the deceased alive on 10:15 am 9-20-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Carmelita A. Cendana M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 9-20-65 | |
| 23C. PHYSICIAN'S NAME (Type) CARMELITA A. CENDANA | | 23D. ADDRESS Mercy Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE SEP 23 1965 | | 24C. NAME of CEMETERY or CREMATORY LORRAINE CEMETERY | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT. SEP 22 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Fickel | | 25C. FUNERAL DIRECTOR Wm. C. Brooks ADDRESS 1050 PARK RD. TOWSON, MD 21204 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

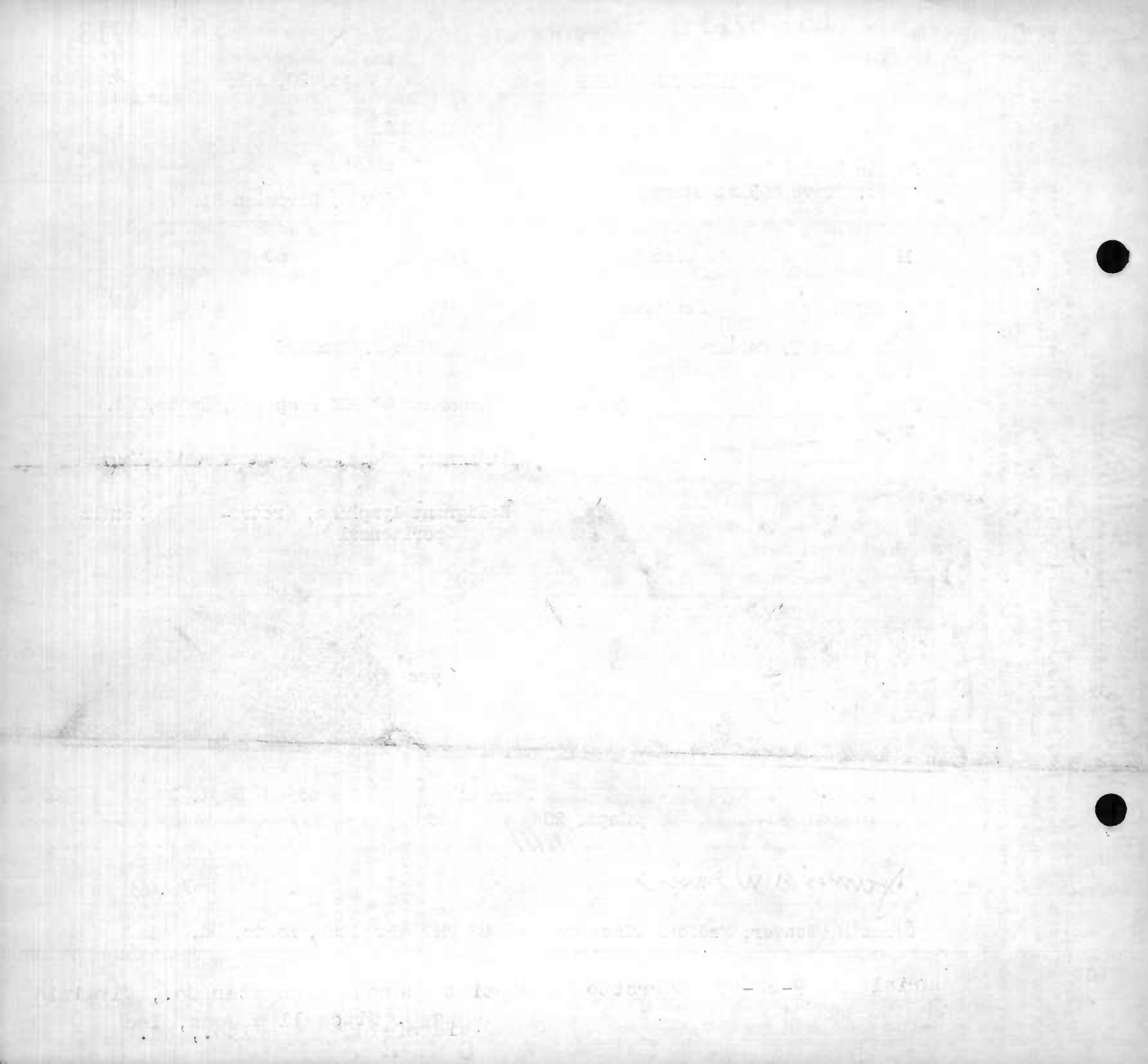
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|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. 65 9712 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9712 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) James Mench | | 2. DATE AND HOUR OF DEATH 9-14-65 7: P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY KENT-64-00 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) WORTON | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital | | D. STREET ADDRESS (If rural, give location) Worton, Maryland, Chestertown | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 11/21/06 | 9. AGE (In years lost birthday) 58 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER | | 10B. KIND OF BUSINESS OR INDUSTRY FARM | | 11. BIRTHPLACE (State or foreign country) Kent Co. Md. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Charles Mench | | 14. MOTHER'S MAIDEN NAME LINDA GEYSER | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-28-3473 | | 17. INFORMANT ADDRESS MRS. JAMES MENCH WORTON MD. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gastric Carcinoma | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 14 months | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION O | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-30-65 to 9-14-65, that (I) (we) last saw the deceased alive on 9-14-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Juan F. Sordo | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-14-65 | |
| 23C. PHYSICIAN'S NAME (Type) JUAN F. SORDO | | 23D. ADDRESS BON SECOURS HOSP. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/18/65 | | 24C. NAME OF CEMETERY or CREMATORY Chester | |
| 24D. LOCATION (City, town, or county) (State) Chestertown Md | | 25A. DATE REC'D BY HEALTH DEPT. SEP 22 1965 | | 25B. NAME OF REGISTRAR Robert E. Fink | |
| 25C. FUNERAL DIRECTOR Edgar L. Lane | | 25D. ADDRESS Church Hill, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9713 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. 65 9713 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) LOMBARD THURSTON CARTER | | 2. DATE AND HOUR OF DEATH Sept. 20, 1965 2:15 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE Md. B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Salisbury Wicomico 72-12 | |
| FULL NAME OF HOSPITAL OR INSTITUTION US Public Health Service Hospital Wyman Pk. Drive & 31st Street 57 | | D. STREET ADDRESS (If rural, give location) 637 S. Division St. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widower | 8. DATE OF BIRTH 5/11/05 | 9. AGE (In years last birthday) 60 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Engineer | | 10B. KIND OF BUSINESS OR INDUSTRY Seafarer | | 11. BIRTHPLACE (State or foreign country) Va. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Lombard T. Carter | | 14. MOTHER'S MAIDEN NAME Alice E. Sanford | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 214-38-4392 | | 17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary edema | | CAUSE OF DEATH (A) DUE TO Malignant lymphoma, retro-peritoneal | | INTERVAL BETWEEN ONSET AND DEATH Hours | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | (B) DUE TO | | (C) | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from June 14 19 65 to Sept. 20 19 65 , that (I) (we) last saw the deceased alive on Sept. 20 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE James M. W. Weaver | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/20/65 | |
| 23C. PHYSICIAN'S NAME (Type) James M. Weaver, Medical Director | | M.D. 23D. ADDRESS US PHS Hospital, Balto, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-22-65 | | 24C. NAME OF CEMETERY or CREMATORY Carrottoman Baptist Church Lancaster Co., Virginia | |
| 24D. LOCATION (City, town, or county) (State) Balto., Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 22 1965 | | 25B. NAME OF REGISTRAR Robert E. Fairley | |
| 25C. FUNERAL DIRECTOR ADDRESS John O. Mitchell & Sons, Inc. Wiedefeld Balto., Md. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9714 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| <div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. 65 9714</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) <u>Siegmund, Christine M.</u></p> </div> <div> <p>2. DATE AND HOUR OF DEATH <u>SEPT. 20, 1965 1:15A M.</u></p> </div> </div> | | | | | |
| <p>3. PLACE OF DEATH <u>IN BALTIMORE, MARYLAND</u></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>44 UNION MEMORIAL HOSPITAL</u></p> | | | <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <u>MD.</u> B. COUNTY <u>BALTO-53-00</u></p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u></p> <p>D. STREET ADDRESS (If rural, give location) <u>6817 Blenheim Rd.</u></p> | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>5/31/91</u> | 9. AGE (In years last birthday) <u>74</u> | <p>If Under 1 Yr. Months Days</p> <p>If Under 24 Hrs. Hours Min.</p> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>HOME</u> | 11. BIRTHPLACE (State or foreign country) <u>BALTO, MD.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> |
| 13. FATHER'S NAME <u>John William KRATZ</u> | | | 14. MOTHER'S MAIDEN NAME <u>Katherine R. BOCKELMAN</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>UNK.</u> | 17. INFORMANT <u>HARRY B. SIEGMUND</u> | | ADDRESS <u>-SAME AS ABOVE</u> |
| <p>18. <u>420.01</u></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> | | | <p>CAUSE OF DEATH</p> <p>(A) <u>CONGESTIVE HEART FAILURE</u></p> <p>DUE TO</p> <p>(B) <u>ARTEROSCLEROTIC HEART DIS.</u></p> <p>DUE TO</p> <p>(C) _____</p> | | <p>INTERVAL BETWEEN ONSET AND DEATH</p> <p><u>6 MOS.</u></p> <p><u>10 YEARS</u></p> |
| <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>CEREBRAL ARTERIOSCLEROSIS & RIGHT HEMIPARESIS 1 YEAR</u></p> | | | | | |
| 19A. DATE OF OPERATION <u>NONE</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ | | 20A. AUTOPSY (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____ | |
| 21D. TIME OF INJURY (APPROX.) _____ | | 21E. INJURY OCCURRED _____ | | 21F. HOW DID INJURY OCCUR? _____ | |
| 22. I certify that (if this hospital) attended the deceased from <u>SEPT. 15</u> 19 <u>65</u> to <u>SEPT. 20</u> 19 <u>65</u> , that (we) last saw the deceased alive on <u>SEPT. 20</u> 19 <u>65</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>L. Evan Custer</u> | | | | 23B. DATE SIGNED <u>Sept. 20, 1965</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>L. EVAN CUSTER,</u> | | 23D. ADDRESS <u>UNION MEMORIAL HOSPITAL</u> | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>9-22-65</u> | 24C. NAME of CEMETERY or CREMATORY <u>Druid Ridge</u> | 24D. LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u> | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 22 1965</u> | 25B. NAME OF REGISTRAR <u>Robert E. Fisher</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>John O. Mitchell & Sons-Wiedefeld 6500 York Rd. Baltimore, Md.</u> | | |

U.S. ARMY HOSPITAL

1000 1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9715 | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 65 9715 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Mary P. Meehan | | 2. DATE AND HOUR OF DEATH 9-18-65 8:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 9-01 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 3941 Lowther Ave (LOWNDES AVE) | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH 6-4-00 | 9. AGE (In years lost birthday) 65 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | 10B. KIND OF BUSINESS OR INDUSTRY HOME | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME John Forester | | 14. MOTHER'S MAIDEN NAME Ruth Duke | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT MR. JEROME J. MEEHAN ADDRESS SAME | |
| 18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | CAUSE OF DEATH (A) DUE TO CVA (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 6 hrs | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-18 1965 to 9-18 1965 , that (I) (we) last saw the deceased alive on 9-18 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Hudson Fesche | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-18-65 | |
| 23C. PHYSICIAN'S NAME (Type) Hudson Fesche | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-21-65 | | 24C. NAME OF CEMETERY or CREMATORY DRUID RIDGE | |
| 24D. LOCATION (City, town, or county) (State) PIKESVILLE, MD. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 22 1965 | | 25B. NAME OF REGISTRAR P. J. E. G. G. G. | | 25C. FUNERAL DIRECTOR MITCHELL-WIEDEFFELD HOME ADDRESS 6500 YORK RD. 21212 | |

MARKYARD

RECEIVED

65 9716

BALTIMORE CITY HEALTH DEPARTMENT

65 9716

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HENRY C. BARTON

2. DATE AND HOUR PRONOUNCED DEAD

September 16, 1965 6:44 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1716 N. Calvert Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1716 N. Calvert St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Aug. 26, 1897

9. AGE (In years
last birthday)

68

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Chauffeur

10B. KIND OF BUSINESS OR INDUSTRY

Trucking

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

George Barton

14. MOTHER'S MAIDEN NAME

Sophie Sparks

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

219-03-1982

17. INFORMANT

ADDRESS

Mrs. Lottie Jory, 4020 Belle Grove Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

September 17, 1965

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-20-1965

23C. NAME of CEMETERY or CREMATORY

Meadowridge Memorial Pl.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 22 1965

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

George J. Gonce, 4001 Ritchie Hwy.

ADDRESS

Baltimore 25, Md.

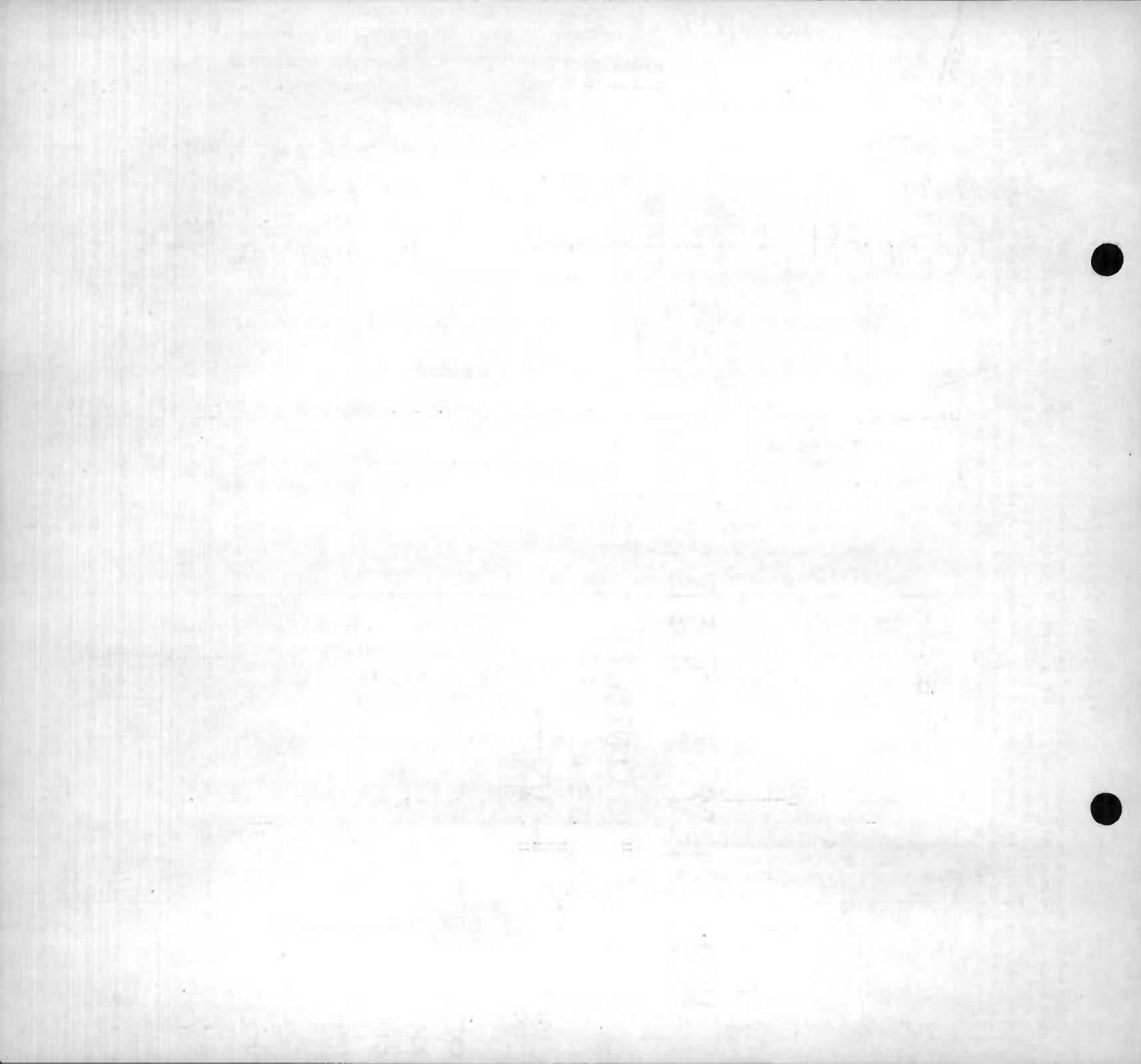
WALLEN FORD

AP 100 100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

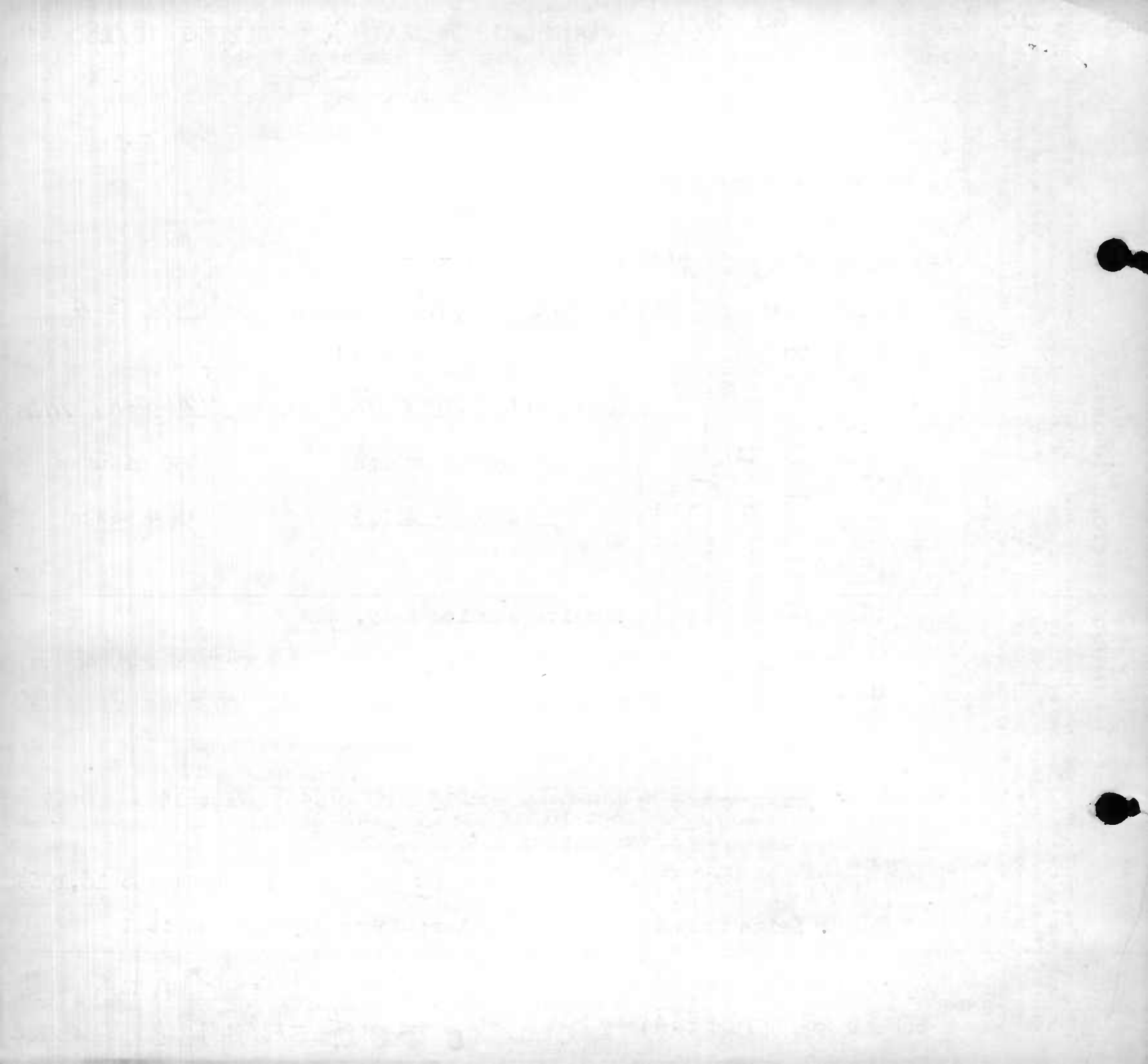
| | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|-----------------------------------------------|---------------------------------------|
| BIRTH NO. 65 9717 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9717 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | Arrowood | | 2. DATE AND HOUR OF DEATH | |
| MRS. FLORENCE ARROWOOD LEABERRY | | | | September-20-65 12.15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| 90 The Ardleigh Nursing Home. (21211) | | Maryland Baltimore City | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore 13-08 | |
| | | D. STREET ADDRESS (If rural, give location) | | 2095 Rockrose Ave. (21211) | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days Hours Min. |
| Female | White | Widow | December-28-1878 | 86yrs | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| NONE | | NONE | | Minnesota U.S. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| William Arrowood | | Nancy Wells | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| no no | | 219-32-1436 | | Mrs. F.A. Leaberry (before death) Baltimore | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 422.1 I | | (A) Arteriosclerotic cardiovascular disease | | 15 yrs. | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 0 | | No | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | | | |
| | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from August 21, 1965 to Sept. 20, 1965, that (I) (we) last saw the deceased alive on Sept. 14, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| Lloyd E. Saylor | | | | Sept. 21, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Lloyd E. Saylor | | M.D. 3902 Greenmount Avenue | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| burial | Sept-23-65 | Louden Park | | Baltimore, Md. 21229 | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | | |
| SEP 22 1965 | Robert E. Taylor | | Stewart & Mowen Co. 108-W-North-Av 21201 | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

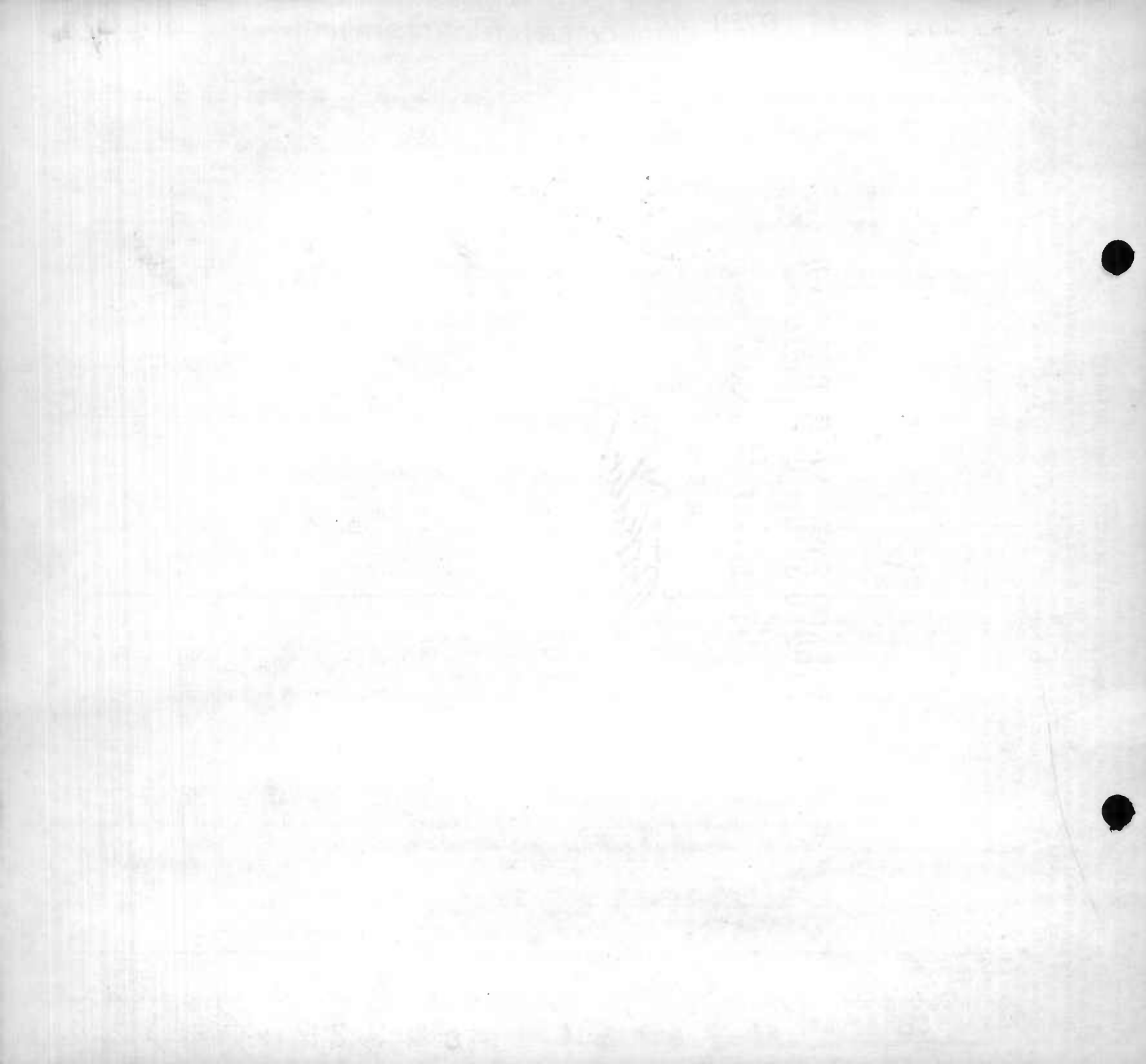
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------|--|--------------------------------------------------------|--------------------------------------------------------------------------------------------------------|------------------|--|---------------------------------|--|---------------------------------------------------------------------------------------|--|-----------------------------|--|--|
| BIRTH NO. 65 9718 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 9718 | | | | |
| M.E. CASE NO. | | | | | 1. NAME OF DECEASED (Type or Print) | | | | | 2. DATE AND HOUR OF DEATH | | | | |
| | | | | | BESSIE BOND | | | | | 9-16-65 4.30 A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | | | | | | | A. STATE B. COUNTY | | | | |
| 33 THE JOHNS HOPKINS HOSPITAL | | | | | | | | | | MARYLAND CHARLES - 58-00 | | | | |
| | | | | | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | |
| | | | | | | | | | | WALDORF | | | | |
| | | | | | | | | | | D. STREET ADDRESS (If rural, give location) | | | | |
| | | | | | | | | | | ROUTE 5 | | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| FEMALE | | NEGRO | | MARRIED | | 11-25-06 | | 58 | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country) | | | | |
| HOUSEWORK | | | | | DOMESTIC | | | | | MARYLAND | | | | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | | 12. CITIZEN OF WHAT COUNTRY? | | | | |
| JAMES SMITH | | | | | MARY HAWKINS | | | | | U.S.A. | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | | 16. SOCIAL SECURITY NO. | | | | | 17. INFORMANT ADDRESS | | | | |
| NO | | | | | 216-22-2489 | | | | | EUGENE MUSCHETTE, WALDORF, MD. | | | | |
| 18. 464X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | | | | | | CAUSE OF DEATH | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | | | | | | (A) PULMONARY EMBOLUS DUE TO | | | | |
| ANTECEDENT CAUSES | | | | | | | | | | (B) THROMBOPHLEBITIS DUE TO | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | | (C) | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | Massive cardiomegaly, CHF | | | | |
| 19A. DATE OF OPERATION | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) | | | | |
| 2 | | | | | | | | | | yes | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 15 1965 to Sept 16 1965, that (I) (we) last saw the deceased alive on Sept 16 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 23A. SIGNATURE | | | | | | | | | | 23B. DATE SIGNED | | | | |
| W. Leigh Thompson | | | | | | | | | | INTERNE Sept 16, 1965 | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | | | | | | 23D. ADDRESS | | | | |
| W. Leigh Thompson | | | | | | | | | | Osler; Johns Hopkins Hospital | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | | 24B. DATE | | | | | 24C. NAME of CEMETERY or CREMATORY | | | | |
| BURIAL | | | | | 9-20-65 | | | | | Newtown Methodist | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | | 25B. NAME OF REGISTRAR | | | | | 25C. FUNERAL DIRECTOR ADDRESS | | | | |
| SEP 22 1965 | | | | | Robert E. Taylor | | | | | Hight Funeral Home | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

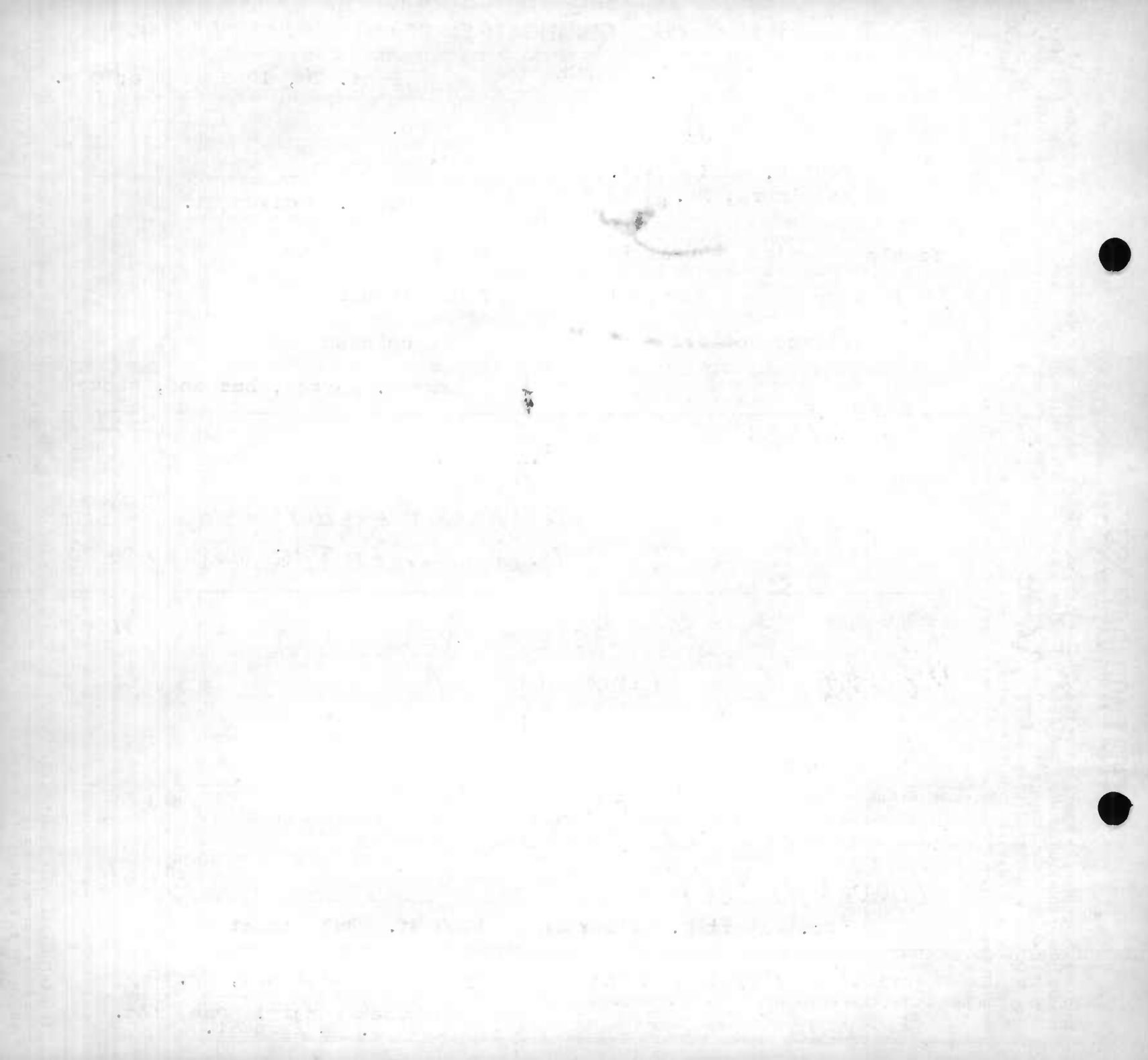
| | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|
| BIRTH NO. <u>15,20065</u> <u>9719</u> | | BALTIMORE CITY HEALTH DEPARTMENT | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>SUSAN E. JENSEN</u> | | 2. DATE AND HOUR OF DEATH <u>9-20-65</u> <u>8:35</u> AM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>38 UNIVERSITY HOSPITAL</u> | | A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO - 5300</u> | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>OWINGS MILLS MD.</u> | |
| | | D. STREET ADDRESS (If rural, give location) <u>27 Straw Hat Rd.</u> | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH <u>8-28-65</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years lost birthday) <u>24</u> |
| 13. FATHER'S NAME <u>THEODORE T. JENSEN</u> | | 14. MOTHER'S MAIDEN NAME <u>ELIZABETH ROCKWELL S/A</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT <u>FATHER, 27 Straw Hat Rd Owings Mills Md.</u> |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease or injury or complication which caused death.) <u>Cerebral Heart Disease</u> | | CAUSE OF DEATH (A) DUE TO <u>11SD, Patent Ductus & Coarctation.</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating underlying condition lost. <u>II</u> | | (B) DUE TO <u>Attempt repair of same</u> | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) DUE TO <u>9-20-65</u> | |
| 19A. DATE OF OPERATION <u>1 9-20-65</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>POA & Coarctation</u> | 20A. AUTOPSY? (Yes or No) <u>yes</u> |
| 21A. ACCIDENT WAS UNDERLIEING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 22. I certify that (1) (this hospital) attended the deceased from <u>9-7</u> 19 <u>65</u> to <u>9-20</u> 19 <u>65</u> , that (1) (we) last saw the deceased alive on <u>9-20</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | 23A. SIGNATURE <u>N. W. Todd</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | |
| 23C. PHYSICIAN'S NAME (Type) <u>N. W. Todd</u> | | 23B. DATE SIGNED <u>9-20-65</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9/22/65</u> | 24C. NAME of CEMETERY or CREMATORY <u>Imperial Church Cemetery, Md.</u> |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 22 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | 25C. FUNERAL DIRECTOR <u>H. J. Harris, Baltimore, Md.</u> |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. 65 9720 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9720 | |
| M.E. CASE NO. | | | 1. NAME OF DECEASED | | |
| (Type or Print) | | | DOROTHY I. KOVACK | | |
| 2. DATE AND HOUR OF DEATH | | | Sept. 20, 1965 6:10 p. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE B. COUNTY | | |
| 2927 E. Madison St., Baltimore, Md. 21205 | | | Md. DEAL | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | Baltimore | | |
| D. STREET ADDRESS (If rural, give location) | | | 2927 E. Madison St. | | |
| 5. SEX | 6. RACE | 7. MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| female | white | married | 2/20/1916 | 49 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Saleslady | | Epstein's | | Pennsylvania | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Wallace Pollock | | | unknown | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | George K. Kovack, husband, above | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | |
| 18. 152.7 I | | | (A) CARCINOMA OF TESTICULUM | | |
| ANTECEDENT CAUSES | | | DUE TO | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | ANN PRALLIC ORGANS | | |
| | | | (B) GENERAL CARCINOMATOSIS | | |
| | | | DUE TO | | |
| | | | (C) CARCINOMA OF TESTICULUM | | |
| | | | 10 MOS. | | |
| | | | 3 MOS. | | |
| | | | 10 MOS. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | BRONCH-PNEUMONIA | | |
| 19A. DATE OF OPERATION | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) |
| 02/14/64 | | | CARCINOMA | | NO |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 11-13-64 19 to 9/20/65 19 that (I) (we) last saw the deceased alive on 9/17/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Albert R. Wilkerson | | | | 9/21/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| Dr. Albert R. Wilkerson, M.D. | | | | 1200 St. Paul Street | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 9/23/65 | | Oak Lawn Cemetery | |
| | | | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| SEP 22 1965 | | Robert E. Taylor, M.D. | | Schimunek Funeral Home, Inc. 2601 E. Madison St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------|----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------|--|
| BIRTH NO. | | 65 9721 | | CERTIFICATE OF DEATH | | Registered No. 65 9721 | | | |
| 1. NAME OF DECEASED (Type or Print) ROBERT E. CEAR Foss | | | | | | 2. DATE AND HOUR OF DEATH SEPT. 17, 1965 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 78-04 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES Hosp. | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO | | | |
| D. STREET ADDRESS (If rural, give location) 207 Boswell Rd | | | | | | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | | 8. DATE OF BIRTH 10/7/14 | 9. AGE (In years lost birthday) 50 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINT MFG. | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MD | | 12. CITIZEN OF WHAT COUNTRY? US | | | |
| 13. FATHER'S NAME DANIEL V. CEAR Foss | | | | 14. MOTHER'S MAIDEN NAME SARAH HAMILL | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ANN E. SARTOFF | | ADDRESS | | | |
| 18. CAUSE OF DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 420.11 | | | | | | (A) MYOCARDIAL INFARCTION DUE TO 2 days | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | (B) Coronary artery disease DUE TO 6 years | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from April 2 19 59 to Sept 17 19 65 , that (I) (we) last saw the deceased alive on Sept 16 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="radio"/> (I) (we) (did) <input type="radio"/> (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Kennard Yaffe | | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9/18/65 | |
| 23C. PHYSICIAN'S NAME (Type) KENNARD YAFFE | | M.D. | | 23D. ADDRESS 5501 Forest Park Ave Balt | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/21/65 | | 24C. NAME OF CEMETERY or CREMATORY MORLAND MEM. CEM | | 24D. LOCATION (City, town, or county) (State) BALTO. CO. MD. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 22 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR E.S. MacNabb | | ADDRESS catonsville MD | | | |

FUNERAL DIRECTOR: IMPORTANT

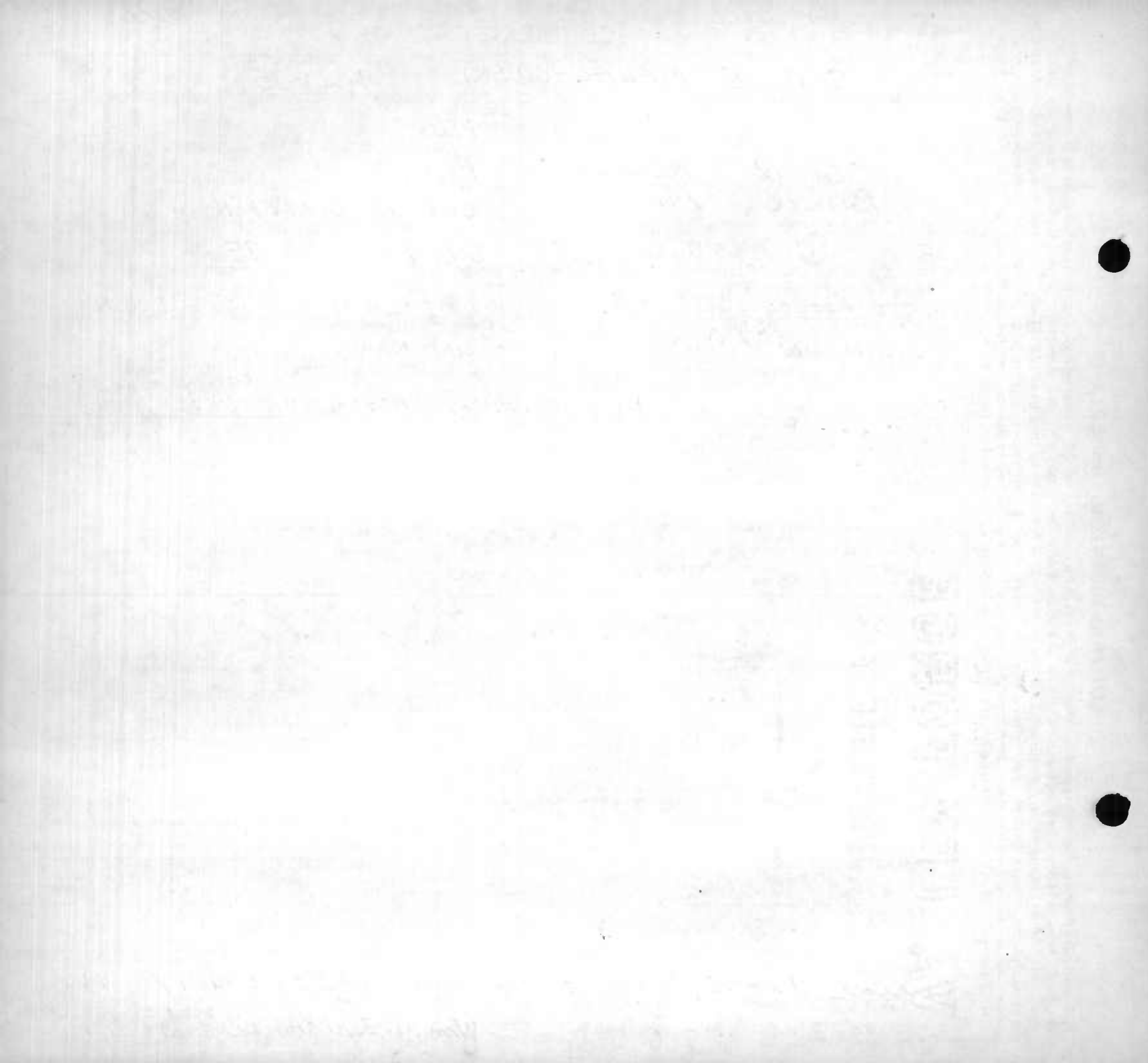
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9722 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|------------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 65 9722 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) STODDARD, ROSE MARY ROSE MARY | | 2. DATE AND HOUR OF DEATH SEPT 20, 1965 11:50A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL 40 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 7505 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1637 CEDDOX ST. #26 | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOW | 8. DATE OF BIRTH 9-9-15 | 9. AGE (In years last birthday) 50 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10B. KIND OF BUSINESS OR INDUSTRY NONE | | 11. BIRTHPLACE (State or foreign country) NEW YORK | |
| 13. FATHER'S NAME BERNARD REILLY | | 14. MOTHER'S MAIDEN NAME ROSEANN CARROLL | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 120-10-2106 | | 17. INFORMANT ST. AGNES HOSPITAL RECORDS; CATON & WILKENS AVES | |
| 18. 150X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause, (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) CANCER OF Oesophagus DUE TO (B) LUNG AND PLEURAL METASTASIS DUE TO (C) Peripheral and Central circulatory failure | | INTERVAL BETWEEN ONSET AND DEATH | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from SEPT 13 19 65 to SEPT 20 19 65 , that (I) (we) last saw the deceased alive on SEPT 20 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Cemil Gosal M.D. | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) CEMIL GOSAL M.D. | | | | 23D. ADDRESS ST. AGNES HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-23-65 | | 24C. NAME of CEMETERY or CREMATORY Holy Cross Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Anne Arundel Co. Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 22 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Fark | | 25C. FUNERAL DIRECTOR Wm. A. Fialkowski ADDRESS 2007 Eastern Ave. BALTO. MD. 21231 | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 65 9723 | | Registered No. | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|------------------------------------------------------------------------------------------|--|----------------|--|
| BIRTH NO. | | | | 65 9723 | | | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| SOPHIE MALACHOWSKI | | | | 9-20-65 3 rd P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| 501 N. STREEPER ST. BALTO., MD. | | | | MD. 7-01 | | | |
| 5. SEX | | | | 6. RACE | | | |
| F | | | | W | | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | | | 8. DATE OF BIRTH | | | |
| WIDOWED | | | | 5-6-90 | | | |
| 9. AGE (In years last birthday) | | | | 10. CITIZEN OF WHAT COUNTRY? | | | |
| 75 | | | | U.S.A. | | | |
| 11. BIRTHPLACE (State or foreign country) | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| POLAND | | | | U.S.A. | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| UNKNOWN | | | | UNKNOWN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| No | | | | 181-05-4076 | | | |
| 17. INFORMANT | | | | ADDRESS | | | |
| MARY YATSONSKY | | | | 501 N. STREEPER ST. BALTO., MD. 21205 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | Interval between ONSET AND DEATH | | | |
| General arterio-sclerosis, cadaveria, senility - etc. intestinal suppurations. | | | | ? | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| D | | | | | | | |
| 20A. AUTOPSY? (Yes or No) | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED | | | |
| | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept. 18 19 65 to Sept 20 19 65, that (I) (we) last saw the deceased alive on Sept 20 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| L.C. Dobichal | | | | Sept 21, 1965 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| L.C. Dobichal | | | | 447 N. Kenwood Ave | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) | | | | 24B. DATE | | | |
| Burial | | | | 9-24-65 | | | |
| 24C. NAME OF CEMETERY or CREMATORY | | | | 24D. LOCATION (City, town, or county) (State) | | | |
| SACRED HEART OF JESUS | | | | BALTO., COUNTY MD. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | | |
| SEP 22 1965 | | | | Robert S. Fairbank | | | |
| 25C. FUNERAL DIRECTOR | | | | 25D. ADDRESS | | | |
| Wm. A. Fialkowski | | | | 2007 Eastern Ave. BALTO., MD. | | | |



FUNERAL DIRECTOR: IMPORTANT

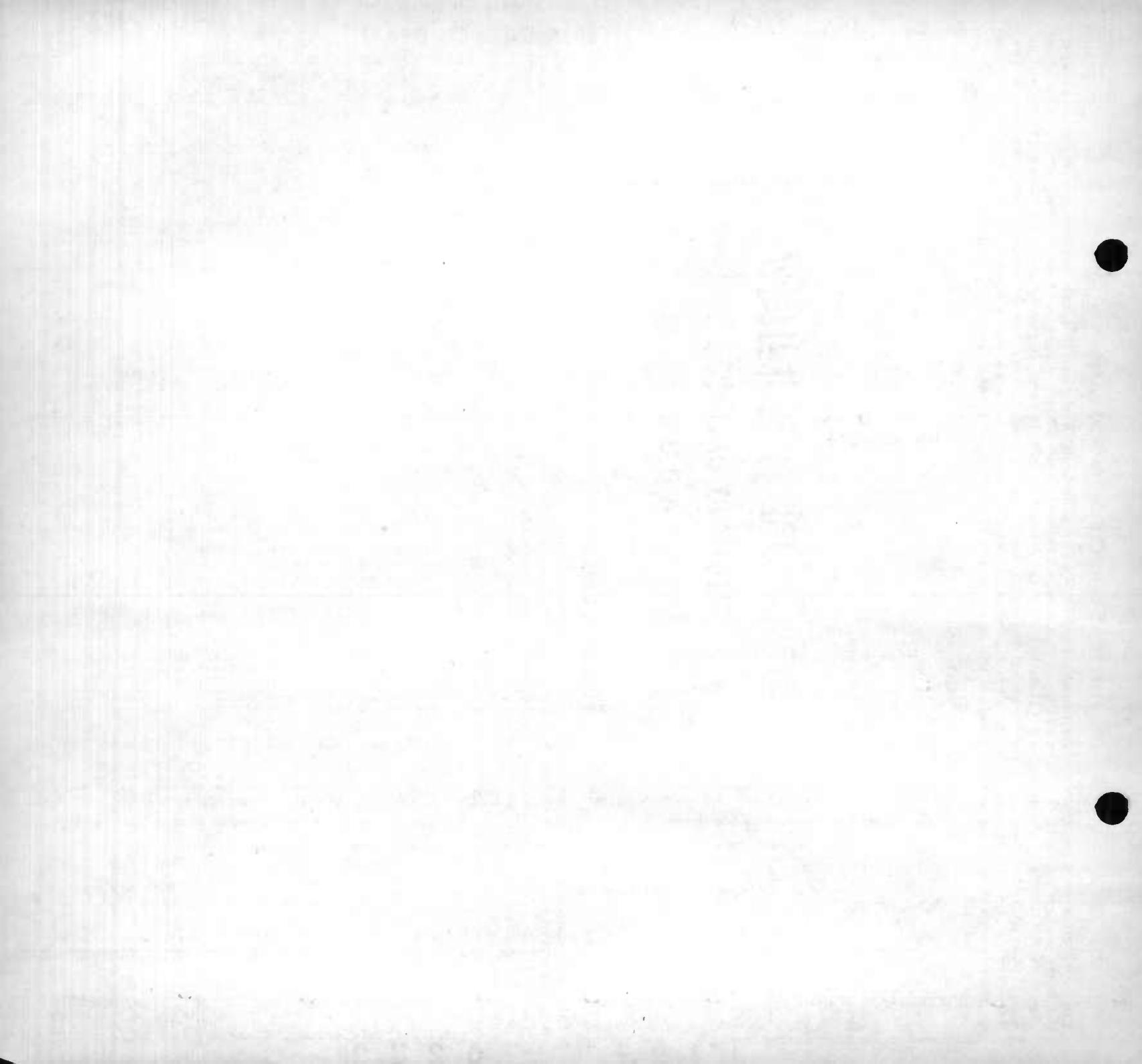
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | | | | |
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| BIRTH NO. 65 9724 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 9724 | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) HELEN PERKINS | | | | | 2. DATE AND HOUR OF DEATH SEPT 19, 1965 11:40 A.M. | | | | | | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI Hospital Inc 42nd St Md. | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) 27-10 | | | | | | | | | |
| 5. SEX F | | | | | 6. RACE N | | | | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED | | | | | | | | | |
| 8. DATE OF BIRTH 8/21/35 | | | | | 9. AGE (In years last birthday) 30 | | | | | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED | | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | | 11. BIRTHPLACE (State or foreign country) Baltimore Md | | | | | | | | | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | 13. FATHER'S NAME Fallsboro Perkins | | | | | 14. MOTHER'S MAIDEN NAME Georgia Perkins Jackson | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | | 16. SOCIAL SECURITY NO. | | | | | 17. INFORMANT ADDRESS Georgia Perkins 4431 Wrenwood Ave | | | | | | | | | |
| 18. E954X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | 19. CAUSE OF DEATH (A) Cerebral Hypoxia (B) Respiratory Arrest (C) Due to | | | | | INTERVAL BETWEEN ONSET AND DEATH 96 hrs | | | | | | | | | |
| MEDICAL CERTIFICATION 19A. DATE OF OPERATION 3/15/65 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fibroids - Endometrium | | | | | 20A. AUTOPSY? (Yes or No) YES. | | | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Sinai Hospital | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Sinai Hospital Bldg. Md | | | | | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 9/15/65 11:00 PM | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? — syncope anesthesia B.S.F. | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/14 to 9/19 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | 23A. SIGNATURE Mauri Roth M.D. | | | | | 23B. DATE SIGNED 9/19/65 | | | | |
| 23C. PHYSICIAN'S NAME (Type) Mauri Roth M.D. | | | | | 23D. ADDRESS Sinai Hospital Inc | | | | | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | | 24B. DATE 9-23-65 | | | | | 24C. NAME of CEMETERY or CREMATORY Mt Auburn Cem. Baltimore, Md. | | | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 22 1965 | | | | | 25B. NAME OF REGISTRAR Robert E. Farley | | | | | 25C. FUNERAL DIRECTOR ADDRESS George A. Kahan 1348 N. Calhoun St | | | | | | | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9725 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9725 | |
| M.E. CASE NO. | | | 1. NAME OF DECEASED (Type or Print) Marie E. Kraft | | |
| 2. DATE AND HOUR OF DEATH September 21, 1965 | | | M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE Maryland | | |
| 1933 Ridgehill Avenue Baltimore, Maryland 21217 | | | B. COUNTY Baltimore | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | D. STREET ADDRESS (If rural, give location) | | |
| Baltimore | | | 1933 Ridgehill Avenue 17 | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH Oct. 9, 1896 | 9. AGE (In years last birthday) 68 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| Housewife | | | Maryland | | |
| 13. FATHER'S NAME George Meagher | | | 14. MOTHER'S MAIDEN NAME Annie Foley | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None | | | 16. SOCIAL SECURITY NO. None | | |
| 17. INFORMANT Mr. Albert Kraft | | | ADDRESS 1933 Ridgehill Avenue Baltimore, Maryland 17 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | |
| 260X I | | | (A) <i>Myelophthisic anemia</i> | | |
| ANTECEDENT CAUSES | | | (B) <i>Arteriosclerosis</i> | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (C) <i>Diabetes mellitus</i> | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Aug 15 1965 to Sept 21 1965, that (I) (we) lost saw the deceased alive on Sept 21 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Nathan E. Needle M.D. | | | | 23B. DATE SIGNED 9/22/65 | |
| 23C. PHYSICIAN'S NAME (Type) NATHAN E. NEEDLE M.D. | | | | 23D. ADDRESS 4211 Park Ave Baltimore | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/25/1965 | | 24C. NAME of CEMETERY or CREMATORY St. Peters Cemetery | |
| 24D. LOCATION Baltimore, Maryland | | 24E. DATE REC'D BY HEALTH DEPT. SEP 22 1965 | | 24F. NAME OF REGISTRAR Robert E. Taylor M.D. | |
| 24G. DATE REC'D BY HEALTH DEPT. SEP 22 1965 | | 24H. NAME OF REGISTRAR Robert E. Taylor M.D. | | 24I. FUNERAL DIRECTOR Wm. J. Tichner & Son | |
| 24J. ADDRESS 17 | | 24K. ADDRESS 17 | | 24L. ADDRESS 17 | |



FUNERAL DIRECTOR: IMPORTANT

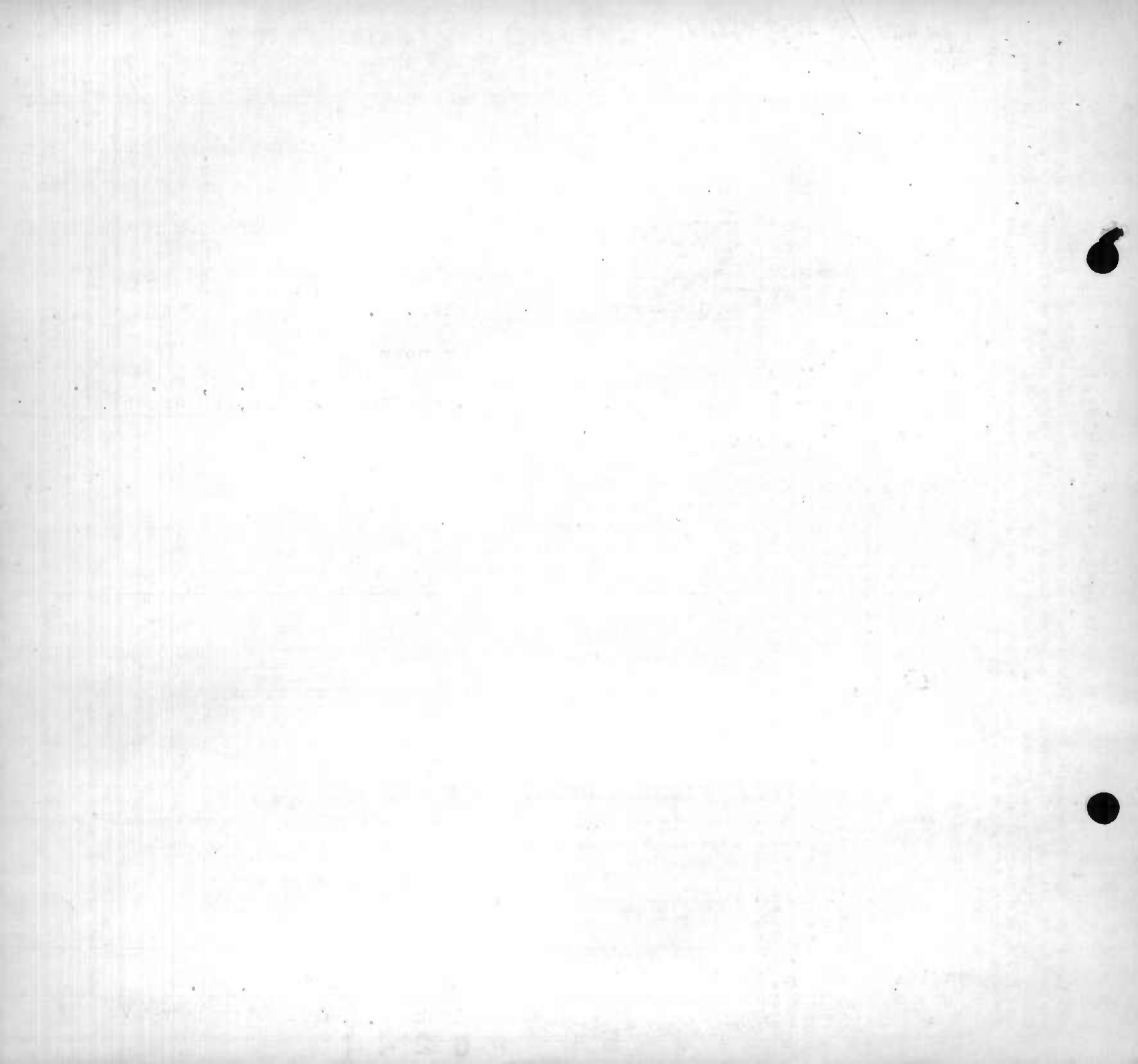
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9726 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9726 | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|----------------------------------------------------------------------|---------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|---------------------------------------------------------------------------------------------|------------------------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Hedwig Garthe</u> | | | | 2. DATE AND HOUR OF DEATH <u>9/20/65 7:10 P.M.</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>12-02</u> | | | |
| 48. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Md. General Hospital Baltimore, Md.</u> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <u>202 Homewood Terrace 18</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Single</u> | 8. DATE OF BIRTH <u>11/4/75</u> | 9. AGE (In years last birthday) <u>89</u> | 10. Under 1 Yr. Months Days | 11. Under 24 Hrs. Hours Min. | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Organist</u> | | | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | | | |
| 13. FATHER'S NAME <u>William Garthe</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Margaret Elizabeth Roeth</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>None</u> | | | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Mr. William Garthe</u> ADDRESS <u>425 Fawcett Street Baltimore, Md. 11</u> | |
| 18. <u>420.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | |
| ANTECEDENT CAUSES | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) <u>Cerebral Thrombosis</u> DUE TO <u>ASHTO Hypertension</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | (B) <u>ASHTO Hypertension</u> DUE TO | | | |
| 19A. DATE OF OPERATION <u>0</u> | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9/20/65</u> to <u>9/20/65</u> and that (I) (we) lost saw the deceased alive on <u>9/20/65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>J. Stephen Margolis</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | | 23B. DATE SIGNED <u>9/20/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>J. Stephen Margolis</u> M.D. | | | | | | 23D. ADDRESS <u>Md. General Hosp.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9/23/1965</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 22 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Wm. J. Tichner & Sons</u> | | ADDRESS <u>Baltimore, Md. 17 North - Pa. Ave.</u> | |

FUNERAL DIRECTOR: IMPORTANT

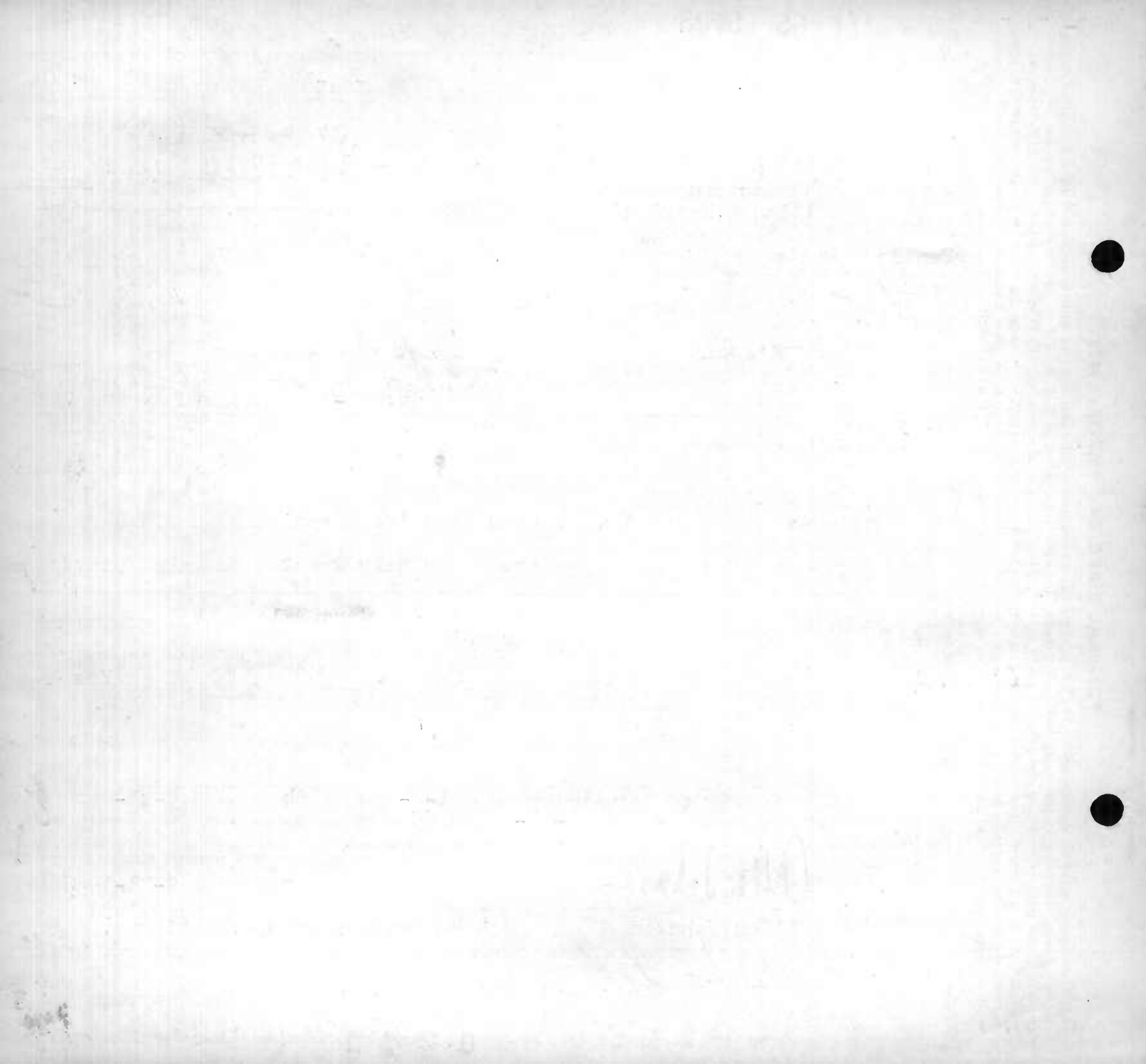
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 65 9727 | | Registered No. 65 9727 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|------------------------------------------------------------------------|-----------------------|
| CERTIFICATE OF DEATH | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <i>ARTH STANLEY</i> | | | | 2. DATE AND HOUR OF DEATH <i>9/19/65 11:25 A.M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Lutheran Hospital of Maryland</i> <i>46</i> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> <i>15-09</i> | | | |
| D. STREET ADDRESS (If rural, give location) <i>3706 Norton Rd.</i> | | | | | | | |
| 5. SEX <i>F</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widow</i> | 8. DATE OF BIRTH <i>Nov 8/1892</i> | 9. AGE (In years last birthday) <i>73</i> | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H.W.</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i> | | 11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Jacob Beck</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Unknown</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Mrs. Chester J. Rose, 122 Greenbrier Rd. Balto. 4, Md.</i> | | | |
| 18. <i>434.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | CAUSE OF DEATH (A) <i>Coronary Heart Failure</i> DUE TO (B) <i>Acute Pulmonary Edema</i> DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9/19</i> 19 <i>65</i> to <i>9/19</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>9/19</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Irma C. Espina</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>9/19/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>IRMA C. ESPINA</i> | | | | 23D. ADDRESS M.D. <i>Lutheran Hospital of Maryland</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>9/22/65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Baltimore Cemetery</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 22 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i> | | 25C. FUNERAL DIRECTOR <i>Witzke F.D. 4101 Edmondson Ave</i> | | ADDRESS | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 65 9728 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9728 | |
| M.E. CASE NO. 1 | | | CERTIFICATE OF DEATH X | | |
| 1. NAME OF DECEASED (Type or Print) Cillar Dye | | | 2. DATE AND HOUR OF DEATH 9-21-1965 4:00A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospital 4940 Eastern Avenue Baltimore, Maryland 21224 | | | A. STATE Maryland 8. COUNTY 15-12 AVE. | | |
| C. CITY OR TOWN (If outside city limits, write RURAL or give name) Baltimore | | | D. STREET ADDRESS (If rural, give location) Hospitals-21224 4940 Eastern Avenue, Baltimore City | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH May 15 / 78 | 9. AGE (In years last birthday) 87 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W. | | 10B. KIND OF BUSINESS OR INDUSTRY Crown Home | 11. BIRTHPLACE (State or foreign country) Tenn. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 13. FATHER'S NAME Ward | | | 14. MOTHER'S MAIDEN NAME Unknown | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 7 | | | 16. SOCIAL SECURITY NO. Records: BCH 4940 Eastern Avenue 21224 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 609X I | | | CAUSE OF DEATH | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | (A) Vasomotor Collapse DUE TO | | |
| ANTECEDENT CAUSES | | | (B) Gram Negative Sepsis DUE TO | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (C) Chronic Urinary Tract Infection DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | Arteriosclerotic Cerebral Vascular Disease | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-8 19 64 to 9-21 19 65 , that (I) (we) last saw the deceased alive on 9-21 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Allen Johnson | | | | 23B. DATE SIGNED 9-21-1965 | |
| 23C. PHYSICIAN'S NAME (Type) Allen Johnson | | | | 23D. ADDRESS M.D. 4940 Eastern Avenue, Baltimore, Maryland | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/24/65 | | 24C. NAME OF CEMETERY or CREMATORY Glen Haven | |
| 24D. LOCATION (City, town, or county) (State) Glen Burnie Md | | 25A. DATE REC'D BY HEALTH DEPT. SEP 22 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor M.D. | | 25C. FUNERAL DIRECTOR W. H. 1101 Edmonds | | | |



FUNERAL DIRECTOR: IMPORTANT

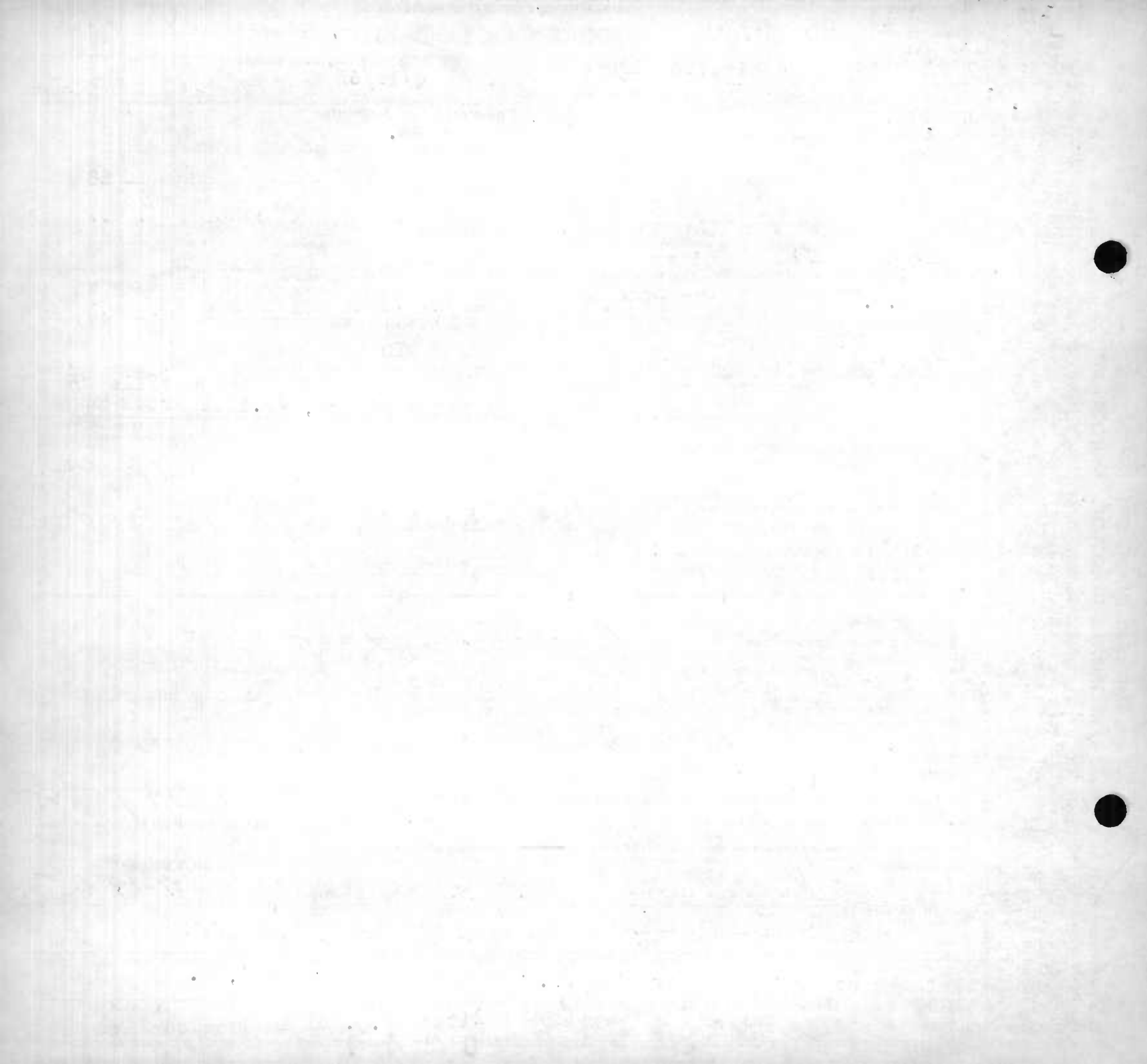
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. 65 9729 | | CERTIFICATE OF DEATH | | 65 9729 | |
| 1. NAME OF DECEASED (Type or Print) Matthew E. Mattson | | | 2. DATE AND HOUR OF DEATH Sept. 19/65 | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 703 Hunting Place | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Ma. B. COUNTY 28-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 29 D. STREET ADDRESS (If rural, give location) 703 Hunting Place | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED Married | 8. DATE OF BIRTH Oct. 15/97 | 9. AGE (In years last birthday) 67 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) New York | |
| 13. FATHER'S NAME Matthew Mattson | | | 14. MOTHER'S MAIDEN NAME Amelia Beckman | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 093 10 8421 | | 17. INFORMANT Mrs. Harriet Mattson, 703 Hunting Place | |
| 18. I 159X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Report C.V. disease | | | CAUSE OF DEATH (A) DUE TO Carcinoma of S.T. tract (B) DUE TO C. Obstruction of colon (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH 1 1/4 years |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1964 to Sept 19 19 65 , that (I) (we) last saw the deceased alive on Sept 19 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE W. J. Levy M.D. | | | 23B. DATE SIGNED 9/20/65 | | |
| 23C. PHYSICIAN'S NAME (Type) 3103 N. Charles St. Baltimore 18, Md. 467-0500 | | | 23D. ADDRESS 3103 N. Charles Street | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9/22/65 | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 22 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR Witzke F.D. 4101 Edmondson Ave | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

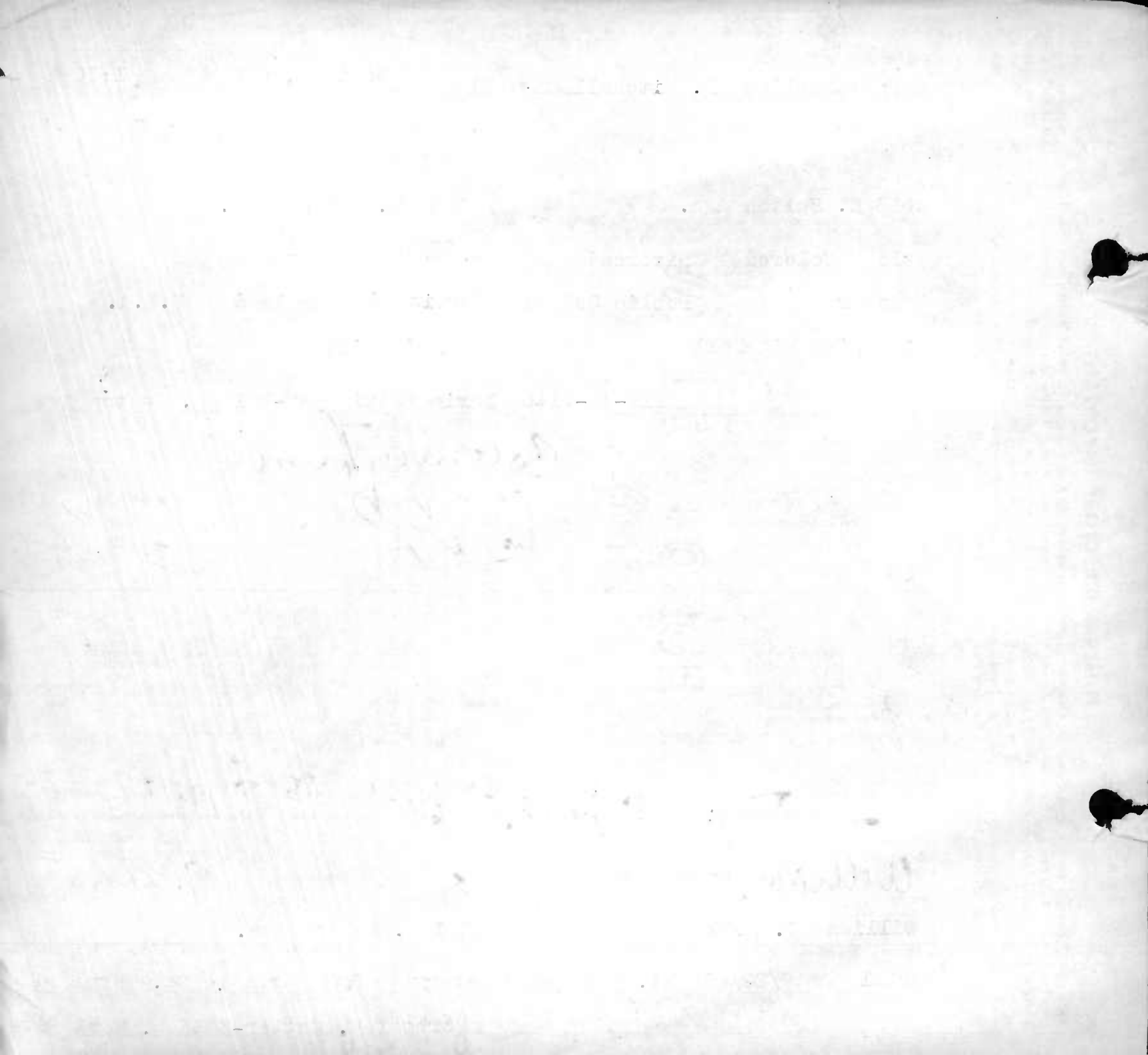
| | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|--|
| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9730 | |
| BIRTH NO. 10 65 9730 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH 9/19/65 9-19-65 10:05 A.M. | |
| 1. NAME OF DECEASED (Type or Print) Antoinette Pirone | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION BCH JECOURS HOSP (If not in hospital or institution, give street address or location) 34 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto-53-00 | |
| 5. SEX Female | | 6. RACE Wh. | |
| 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow | | 8. DATE OF BIRTH 7-22-08 | |
| 9. AGE (In years last birthday) 57 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W. | |
| 11. BIRTHPLACE (State or foreign country) N. Y. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Harry Di Domenico | | 14. MOTHER'S MAIDEN NAME DID | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Nicholas Pirone, Jr. | | ADDRESS 1311 Brook Rd | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtemia, etc. It means the disease, injury or complication which caused death.) Peritonitis | | INTERVAL BETWEEN ONSET AND DEATH 1 week | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Diverticulitis sigmoid (acute) | | 3 months? | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bronchopneumonia | | | |
| 19A. DATE OF OPERATION 9-14-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Diverticulitis (colostomy) | |
| 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-23-1965 to 9-19-1965 , that (I) (we) lost saw the deceased olive on 9-19-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE S. G. Sullivan | | 23B. DATE SIGNED 9-19-65 | |
| 23C. PHYSICIAN'S NAME (Type) S. G. SULLIVAN | | 23D. ADDRESS 1129 St Paul St. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Entombment | | 24B. DATE 9/22/65 | |
| 24C. NAME OF CEMETERY OR CREMATORY Lorraine Pk. Mausoleum | | 24D. LOCATION (City, town, or county) (State) Baltimore 7, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 22 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR Witzke F.D. | | ADDRESS 4101 Edmondson Ave | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------|
| BIRTH NO. 65 9731 | | CERTIFICATE OF DEATH | | Registered No. 65 9731 | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) Evangeline P. Mitchell Caswell | | | Sept 19, 1965 1:30 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 2018 N. Fulton Ave. | | | A. STATE Maryland B. COUNTY 15-04 | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) 2018 N. Fulton Ave. | | |
| 5. SEX Female | 6. RACE Colored | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Divorced | 8. DATE OF BIRTH 8/25/1904 | 9. AGE (In years last birthday) 61 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher | | 10B. KIND OF BUSINESS OR INDUSTRY Public School | 11. BIRTHPLACE (State or foreign country) Curtis Bay Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Nathaniel Mitchell | | | 14. MOTHER'S MAIDEN NAME Annie Gill | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 214-40-5140 | 17. INFORMANT Marie Pettigrew -2018 N. Fulton Ave | | |
| 18. 420.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Coronary Thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. N.C.V.D. C.V.A. | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 2 months |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from July 31 1965 to Sept. 19 1965 that (I) (we) last saw the deceased alive on Sept 19 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE William G. Polk | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9.21.65 |
| 23C. PHYSICIAN'S NAME (Type) William G. Polk | | | 23D. ADDRESS 1141 N. Fulton Ave. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9/22/65 | 24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cemetery | | 24D. LOCATION (City, town, or county) (State) Anne Arundle Co. Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 22 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Herbert E. Nutter-3035 W. North Ave. | |



1
5-570

65 9732

BALTIMORE CITY HEALTH DEPARTMENT

65 9732

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

CHARLES SIMMS

2. DATE AND HOUR PRONOUNCED DEAD

9/18/65

9:09 pm M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

43 - South Baltimore General

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1526 Chesapeake Ave.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

6/13/1932

9. AGE (In years last birthday)

33

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Machine Helper

10B. KIND OF BUSINESS OR INDUSTRY

Brick Company

11. BIRTHPLACE (State or foreign country)

Jessup A.A.Co.Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Herbert Simms

14. MOTHER'S MAIDEN NAME

Dora Allen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

8/22/52-7/21/56

16. SOCIAL SECURITY NO.

725-09-1113

17. INFORMANT

ADDRESS

Dora Brown-Box -#32-B Jessup Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CRANIOCEREBRAL INJURY

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Chesapeake Ave. west of Sun St.

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

9/18/65 8:45 p.

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

pedestrian struck by car

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Werner U. Spitz, M. D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/19/65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

9/23/65

23C. NAME of CEMETERY or CREMATORY

Baltimore National Cem. Baltimore Maryland

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

SEP 22 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Herbert E. Nutter-3035 W. North Ave

ADDRESS

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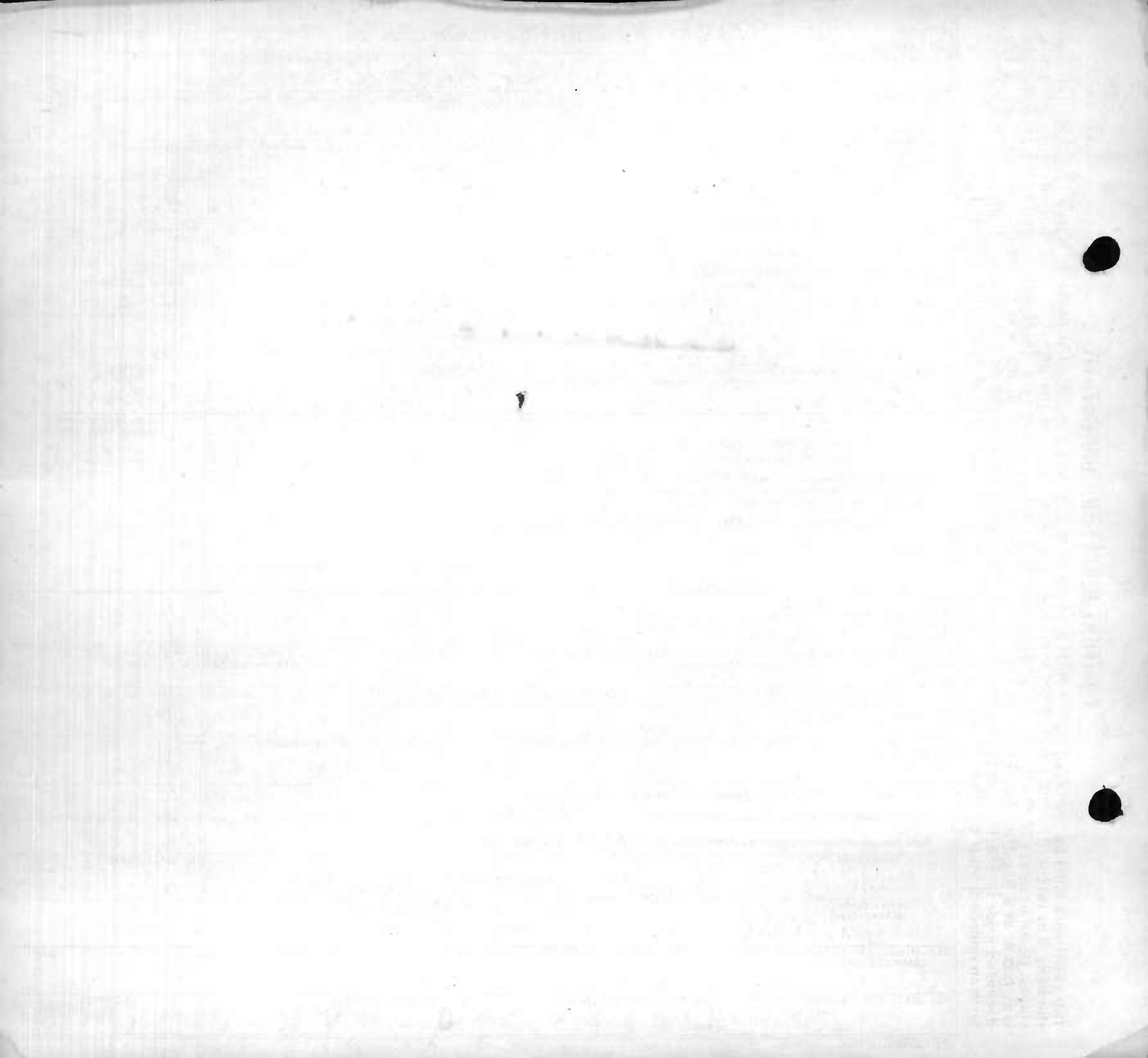
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------|--|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------|--|----------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------|--|--|----------------------------------------------------------------------|--|--|--|--|
| BIRTH NO. 65 9733 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 9733 | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) STANLEY (STANISLAUS) J. SADOWSKI | | | | | | | | | | 2. DATE AND HOUR OF DEATH 9-18-65 | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME & HOSP. | | | | | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 6-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 120 N. MONTFORD AVE. | | | | | | | | | |
| 5. SEX M | | 6. RACE W | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | | 8. DATE OF BIRTH 5-2-1922 | | 9. AGE (in years last birthday) 43 | | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | | | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST | | | | | 10B. KIND OF BUSINESS OR INDUSTRY MACK TRUCK CO. | | | | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | |
| 13. FATHER'S NAME JOHN SADOWSKI | | | | | | | | | | 14. MOTHER'S MAIDEN NAME ANTOINETTE BARTOLD | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | | 16. SOCIAL SECURITY NO. — | | | | | 17. INFORMANT Mrs. Antoinette R. Sadowski | | | | | ADDRESS 120 N. Montford Ave. | | | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Cardio-vascular Disease | | | | | | | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | | | | INTERVAL BETWEEN ONSET AND DEATH instant 4 yrs | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. — | | | | | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20A. AUTOPSY? (Yes or No) | | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-31 1963 to 9-18-1965 , that (I) (we) last saw the deceased alive on 7-27 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 23A. SIGNATURE Wm Carl Ebeling | | | | | | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | | 23B. DATE SIGNED 9-21-65 | | | | |
| 23C. PHYSICIAN'S NAME (Type) WM. CARL EBELING | | | | | M.D. 23D. ADDRESS 410 Med Arts Bldg Balto Md | | | | | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | | | 24B. DATE 9-22-65 | | | | | 24C. NAME of CEMETERY or CREMATORY ST. STANISLAUS Cem. | | | | | 24D. LOCATION (City, town, or county) (State) BALTO. MD. | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 22 1965 | | | | | 25B. NAME OF REGISTRAR Robert E. Stanley | | | | | 25C. FUNERAL DIRECTOR Stanley Ebeling | | | | | ADDRESS -2334 Jeffersville | | | | |



65 9734

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

65 9734

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

LILLIAN COPELAND

2. DATE AND HOUR PRONOUNCED DEAD

9/18/65 9:35 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

South Baltimore General

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

307 Raleigh Rd.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

12-24-1904 60

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Lottsburg VA

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

unk.

14. MOTHER'S MAIDEN NAME

unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

212-10-7522

17. INFORMANT

ADDRESS

Lillian E. Copeland

307 Raleigh Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/19/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-23-65

23C. NAME OF CEMETERY or CREMATORY

BALTO. NATIONAL

23D. LOCATION

(City, town, or county)

Baltimore

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 22 1965

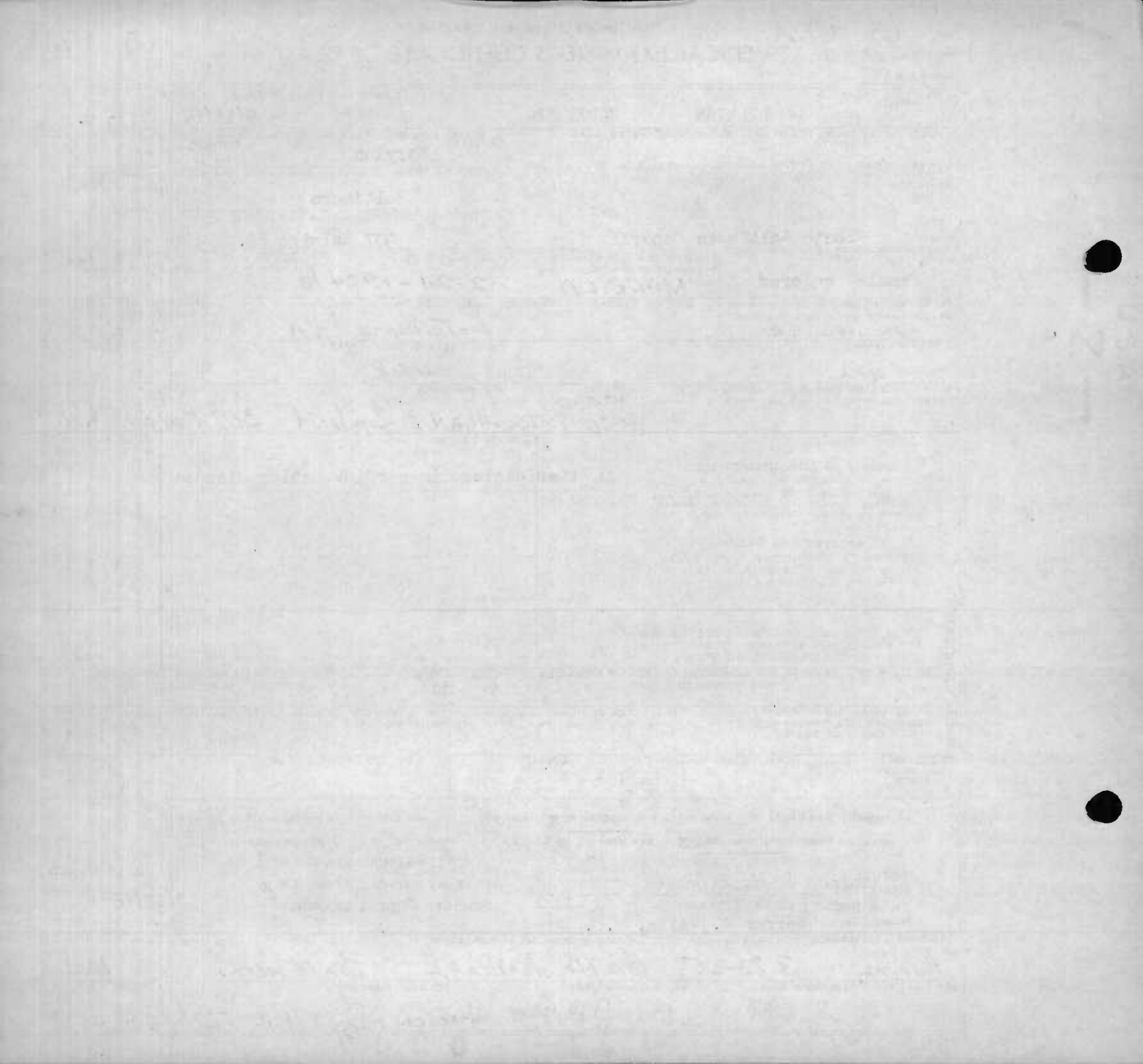
24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Morton + Dyett F.H. 1701 Laurens ST.

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|----------------------------------------------------------------------|--|--|
| BIRTH NO. 65 9735 | | | | | CERTIFICATE OF DEATH | | | | |
| M.E. CASE NO. | | | | | Registered No. 65 9735 | | | | |
| 1. NAME OF DECEASED (Type or Print) WARD, James Arthur | | | | | 2. DATE AND HOUR OF DEATH 9-17-65 1:33 PM | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lincoln Memorial Nursing Home 27 W. Carey Street | | | | | A. STATE MD B. COUNTY Cecil | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Elkton | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 105 Booth St | | | | |
| 5. SEX Male | 6. RACE Colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow | 8. DATE OF BIRTH 4-2-85 | 9. AGE (In years last birthday) 80 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PARA HANGER | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Cecil Co. Md | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Robert Ward | | | | | 14. MOTHER'S MAIDEN NAME HENNETTA LONGOR | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS VERA McCall + 240 N. Angle Ave N.Y. N.Y. | | | | |
| 18. 442X I CAUSE OF DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | | (A) DUE TO Cardiovascular Disease | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (B) DUE TO Arteriosclerosis | | | | |
| | | | | | (C) DUE TO nephritis | | | | |
| | | | | | umbilical Hernia | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Aug 31 1965 to Sept 17 1965 , that (I) (we) last saw the deceased alive on Sept 16 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Thos R Johnson M.D. | | | | | 23B. DATE SIGNED 9-17-65 | | 23C. PHYSICIAN'S NAME (Type) Thos R Johnson M.D. | | |
| 23D. ADDRESS 403 Market St | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-20-65 | | 24C. NAME OF CEMETERY or CREMATORY MANNOR Cemetery | | 24D. LOCATION (City, town, or county) (State) CHESTER Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 22 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR ADDRESS the morton + dyett F.H. Inc. 1701-31 Lawrence St | | | | | |

CHAS. J. HARRIS

WARRIOR

1
W 425

65 00912
65 9736

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 9736

M.E. CASE NO.

| | | | |
|---------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | |
| STEVEN WILSON | | 9/18/65 8:45 p. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE Maryland | |
| Bon Secours Hospital | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 20-02 | |
| D. STREET ADDRESS (If rural, give location) 2534 W. Fairmount Ave. | | 5. SEX male | |
| 6. RACE colored | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) INFANT | |
| 8. DATE OF BIRTH 1-5-1965 | | 9. AGE (In years last birthday) 8 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT | | 10B. KIND OF BUSINESS OR INDUSTRY INFANT | |
| 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Archie Wilson | | 14. MOTHER'S MAIDEN NAME ANNIE MACK | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. INFANT | |
| 17. INFORMANT A. Wilson | | ADDRESS 2534 W. FAIRMOUNT AVE. | |

| | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------|
| 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Interstitital pneumonitis | | |
| (A) DUE TO | | |
| (B) DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| | | | |
|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| 19A. DATE OF OPERATION 2 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) yes | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

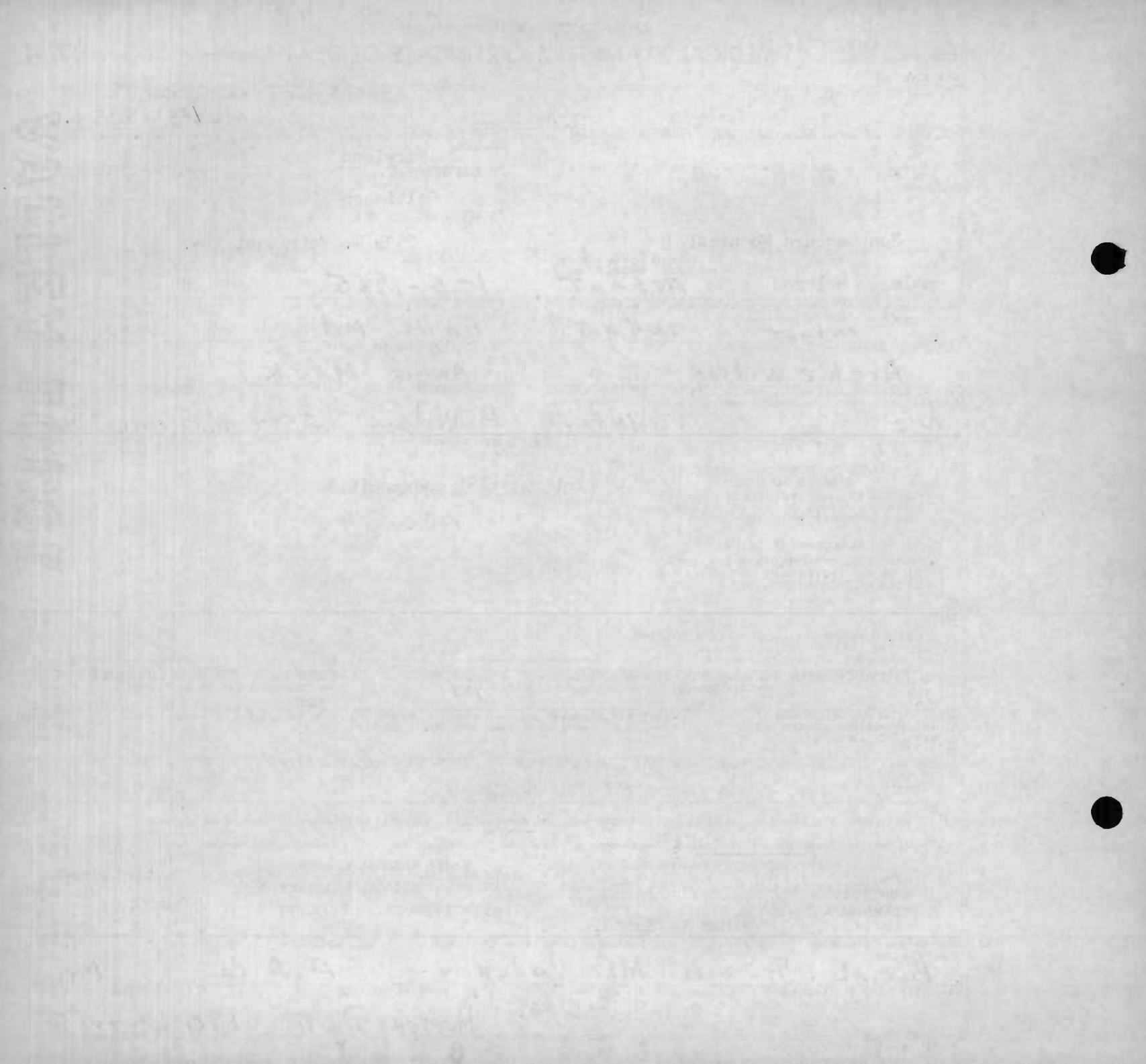
ACTUAL SIGNATURE Werner U. Spitz M.D. CHIEF MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER ☒ DATE SIGNED 9/19/65

ASSOCIATE MEDICAL EXAMINER ☐

| | | | |
|----------------------------------------------------|----------------------------------------------|---------------------------------------------------|----------------------------------------------------------------|
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | 23B. DATE 9-22-65 | 23C. NAME of CEMETERY or CREMATORY MT. CALVARY | 23D. LOCATION (City, town, or county) (State) A.A. Co., Md. |
| 24A. DATE REC'D BY HEALTH DEPT. SEP 22 1965 | 24B. NAME OF REGISTRAR Robert E. Fairbank | 24C. FUNERAL DIRECTOR MORTON DYE | ADDRESS 1701 Laurens ST. |

19650008251



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9737 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9737 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------------------|--|
| 1. NAME OF DECEASED (Type or Print) Mabel Taylor | | | | 2. DATE AND HOUR OF DEATH 9/21/65 9:40 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital of Maryland | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 16-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1944 W. Mosher St. | | | |
| 5. SEX F | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow | 8. DATE OF BIRTH 3/26/1896 | 9. AGE (In years last birthday) 69 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Fairfield, S. C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Ransom Simon | | | | 14. MOTHER'S MAIDEN NAME UNK. | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 217-204642 | | 17. INFORMANT Mrs. Willie M. Kennedy | | ADDRESS 1944 W. Mosher | |
| 18. 600.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH (A) Chronic Pyelonephritis DUE TO (B) Chronic Uremia DUE TO (C) Hypertension | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) 1 Month 1 Day 1 Year 1 Hour | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) <u>this hospital</u> attended the deceased from <u>9/11/65</u> 19 <u>65</u> to <u>9/21</u> 19 <u>65</u> , that (I) <u>we</u> last saw the deceased alive on <u>9/21</u> 19 <u>65</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Inia C. Espina | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/21/65 | |
| 23C. PHYSICIAN'S NAME (Type) INIA C. ESPINA | | | | 23D. ADDRESS M.D. Lutheran Hospital of Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-25-65 | | 24C. NAME OF CEMETERY or CREMATORY MT. CALVARY | | 24D. LOCATION (City, town, or county) (State) A.A. Co. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 22 1965 | | 25B. NAME OF REGISTRAR Robert E. Fairman | | 25C. FUNERAL DIRECTOR ADDRESS MORTON + Dyett 1701 Laurens ST. | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 65-9738 | | Registered No. 65 9738 | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|---------------------------------------------------------------------------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) Viola Hines | | 2. DATE AND HOUR OF DEATH 9-19-65 1 10 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 17-03 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 758 Dolphin St. | | | | D. STREET ADDRESS (If rural, give location) 758 Dolphin St. | | | |
| 5. SEX Fe. | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | B. DATE OF BIRTH 9-25-1924 | 9. AGE (In years last birthday) 40 | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAID | | 10B. KIND OF BUSINESS OR INDUSTRY Hotel | | 11. BIRTHPLACE (State or foreign country) Elizabeth City, N.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME George Matthews | | | | 14. MOTHER'S MAIDEN NAME Martha ? | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Caddy Hines | | ADDRESS 758 Dolphin St. | |
| 18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Arteriosclerosis II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertensive Cardis-vascular disease | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH unknown | |
| MEDICAL CERTIFICATION | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Aug 19 63 to Sept 19 65 , that (I) (we) last saw the deceased alive on September 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Royston B. Scott M.D. | | | | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Sept 21 65 | |
| 23C. PHYSICIAN'S NAME (Type) ROYSTON B. SCOTT M.D. | | | | 23D. ADDRESS 18014 Belterme St | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-22-65 | | 24C. NAME OF CEMETERY or CREMATORY MT. Auburn | | 24D. LOCATION (City, town, or county) (State) Balto., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 22 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Morton & Dyett 1701 Laurens St. | | | |

BIRTH NO.

65 9739

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65 9739

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ELLIOTT WHITE

2. DATE AND HOUR PRONOUNCED DEAD

9/19/65 5:35 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Joseph Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

8-06

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1707 N. Durham St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

12-10-1942

9. AGE (In years
last birthday)

22

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Suffolk, VA

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Axum White

14. MOTHER'S MAIDEN NAME

Lois Scott

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

229-54-1415

17. INFORMANT

Lois White

ADDRESS

1707 N. Durham St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)(A) Retroperitoneal hemorrhage
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Gunshot wound of abdomen
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

street

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Harford Rd. and Normal Ave.

21D TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
9 19 65 2:20 a.

21E INJURY OCCURRED

WHILE AT
m. WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

shot during altercation

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Warner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/19/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-23-65

23C. NAME of CEMETERY or CREMATORY

Laura Hill Cemetery

23D. LOCATION

(City, town, or county)

Holland

(State)

VA.

24A. DATE REC'D BY HEALTH DEPT.

SEP 22 1965

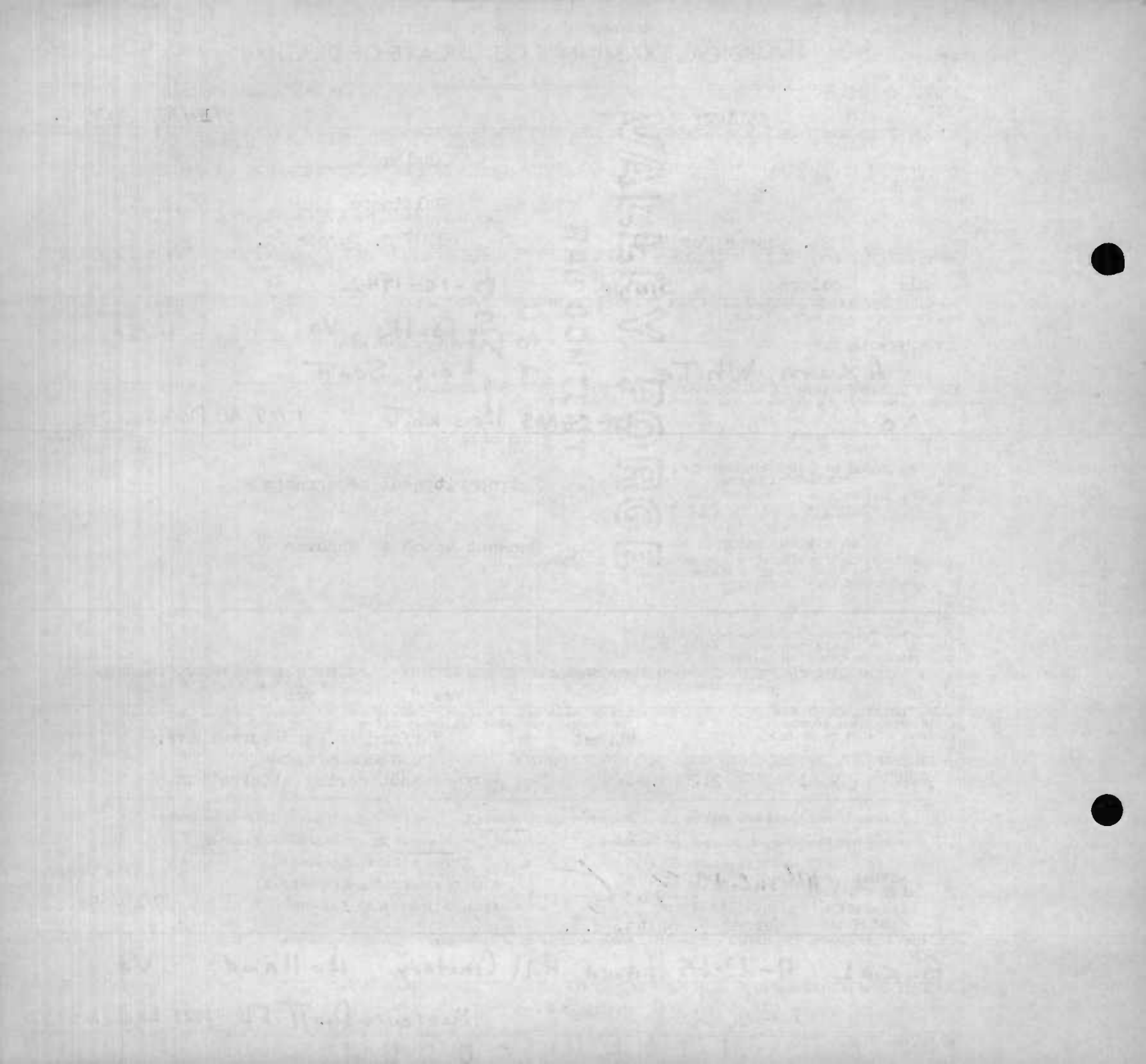
24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Morton + Dyett F.H. 1701 Laurens St.

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>65 9740</u> | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|-----------------------------------------------------------------------------|------------------------------------------|
| BIRTH NO. <u>65 9740</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Geter, Lnd R.</u> | | 2. DATE AND HOUR OF DEATH <u>9/20/65 7:35 P</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | M. <u>15-04</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>46 Lutheran Hosp of Maryland</u> | | A. STATE <u>MD.</u> | | B. COUNTY | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>1824 Walbrook Ave 17.</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>Negro</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>married</u> | 8. DATE OF BIRTH <u>April 1, 1926</u> | 9. AGE (In years last birthday) <u>39</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>coca cola Laborer</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Mt Holly N.C.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Jack Geter</u> | | 14. MOTHER'S MAIDEN NAME <u>Willie Mae Rankin</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, give war or dates of service) <u>World War II</u> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <u>Marie Geter 1824 Walbrook Ave</u> | |
| 18. <u>331X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) <u>Subarachnoid Hemm</u> DUE TO (B) <u>Mid-brain Hemm</u> DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs.</u> | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <u>1</u> | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9/20</u> <u>1965</u> to <u>9/20</u> <u>1965</u> , that (I) (we) last saw the deceased alive on <u>9/20</u> <u>1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>C S Shin</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>9/20/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Cheung Soo Shin</u> | | 23D. ADDRESS <u>M.D.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 24B. DATE <u>Sept 26/65</u> | 24C. NAME OF CEMETERY OR CREMATORY <u>Bald Natl Cemetery</u> | | 24D. LOCATION (City, town, or county) (State) <u>5501 Fredrick ex</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 22 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>Frank T. Tolson 1129 N. Caroline St</u> | |

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on the 11th of
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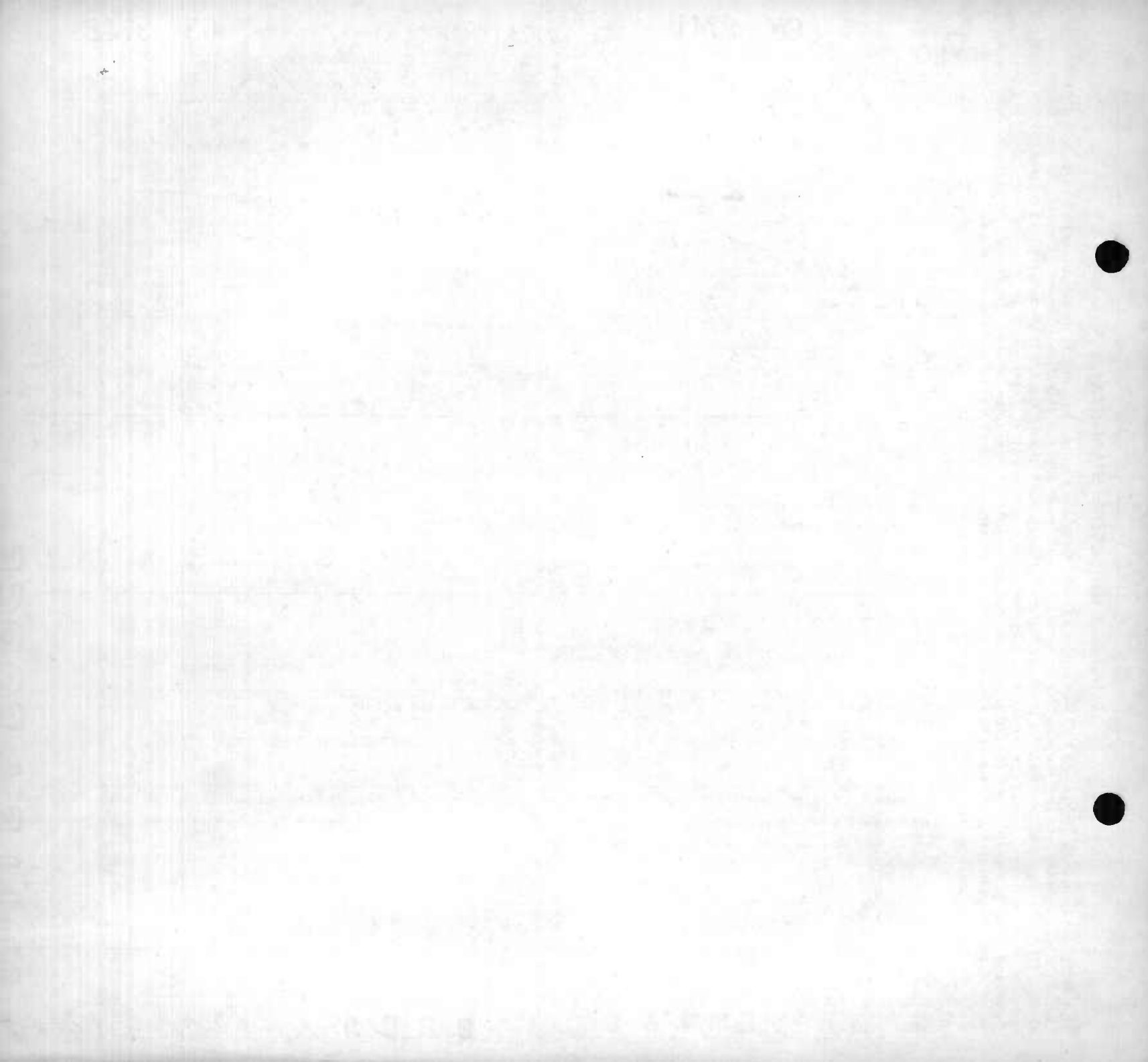
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the 11th of

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9741 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 65 9741 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <i>Harris, Solomon</i> | | | 2. DATE AND HOUR OF DEATH <i>9/20/65 6:30 P. M.</i> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>George Washington Home</i> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>607 Penn. Ave</i> | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>607 Penn. Ave</i> | | |
| 5. SEX <i>M</i> | 6. RACE <i>Negro</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Divorced</i> | 8. DATE OF BIRTH <i>3-17-20</i> | 9. AGE (In years last birthday) <i>45</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Bethlehem Steel</i> | | 11. BIRTHPLACE (State or foreign country) <i>Virginia</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | 13. FATHER'S NAME <i>Augustus</i> | | |
| 14. MOTHER'S MAIDEN NAME <i>Susie Stonesheel</i> | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT <i>George Washington Home</i> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) <i>Meningeal Brain</i> DUE TO (B) <i>Ch. Brain Syndrome</i> DUE TO (C) <i>Parkinson Syndrome</i> | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <i>9-9-65</i> to <i>9-20-65</i> , that (I) (we) last saw the deceased alive on <i>9-9-65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <i>W. L. Leake</i> | | | 23B. DATE SIGNED <i>9-20-65</i> | | |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS <i>1944 Druid Hill Ave Baltimore, Md.</i> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Removal</i> | | 24B. DATE <i>9/22/65</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Hackberry</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Danville, Va</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 22 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Galt</i> | |
| 25C. FUNERAL DIRECTOR <i>Joseph B. Rock</i> | | 25D. ADDRESS <i>1304 N. Central</i> | | | |



BIRTH NO.

65

9742

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JULIA GARRISON (SIMRIL)

2. DATE AND HOUR PRONOUNCED DEAD

September 19, 1965 8:40 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

403 East 23rd Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

5-3-1903

9. AGE (In years
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

COOK

10B. KIND OF BUSINESS OR INDUSTRY

RESTAURANT

11. BIRTHPLACE (State or foreign country)

NORTHHEIM, Va.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

WILLIAM VENNEY

14. MOTHER'S MAIDEN NAME

MARGARET VENNEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

—

17. INFORMANT

MARGARET BIRD CAMDEN, N.J.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9-20-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

9-25-65

23C. NAME OF CEMETERY or CREMATORY

MT. GALVARY

23D. LOCATION

(City, town, or county)

(State)

Glen Burnie-A.A.G. MD.

24A. DATE REC'D BY HEALTH DEPT.

SEP 22 1965

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

Marshall W. Jones, Jr.

ADDRESS

1735-37
HARFORD AVE

WALLING REPORT

CHARTER (2011)

50

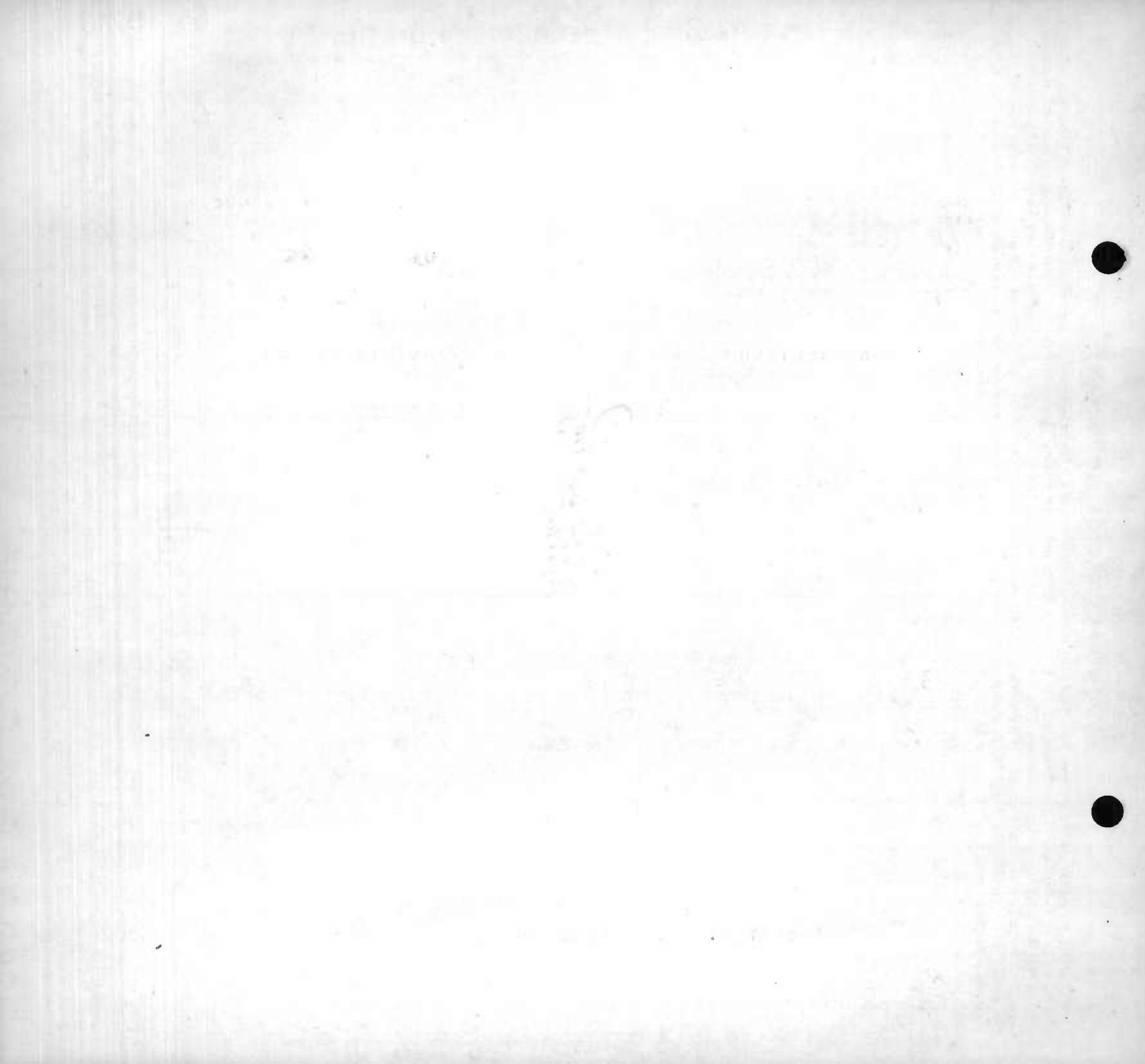
2011-2012

Released on Approval - By Dr Spitz - OF ME'S OFFICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

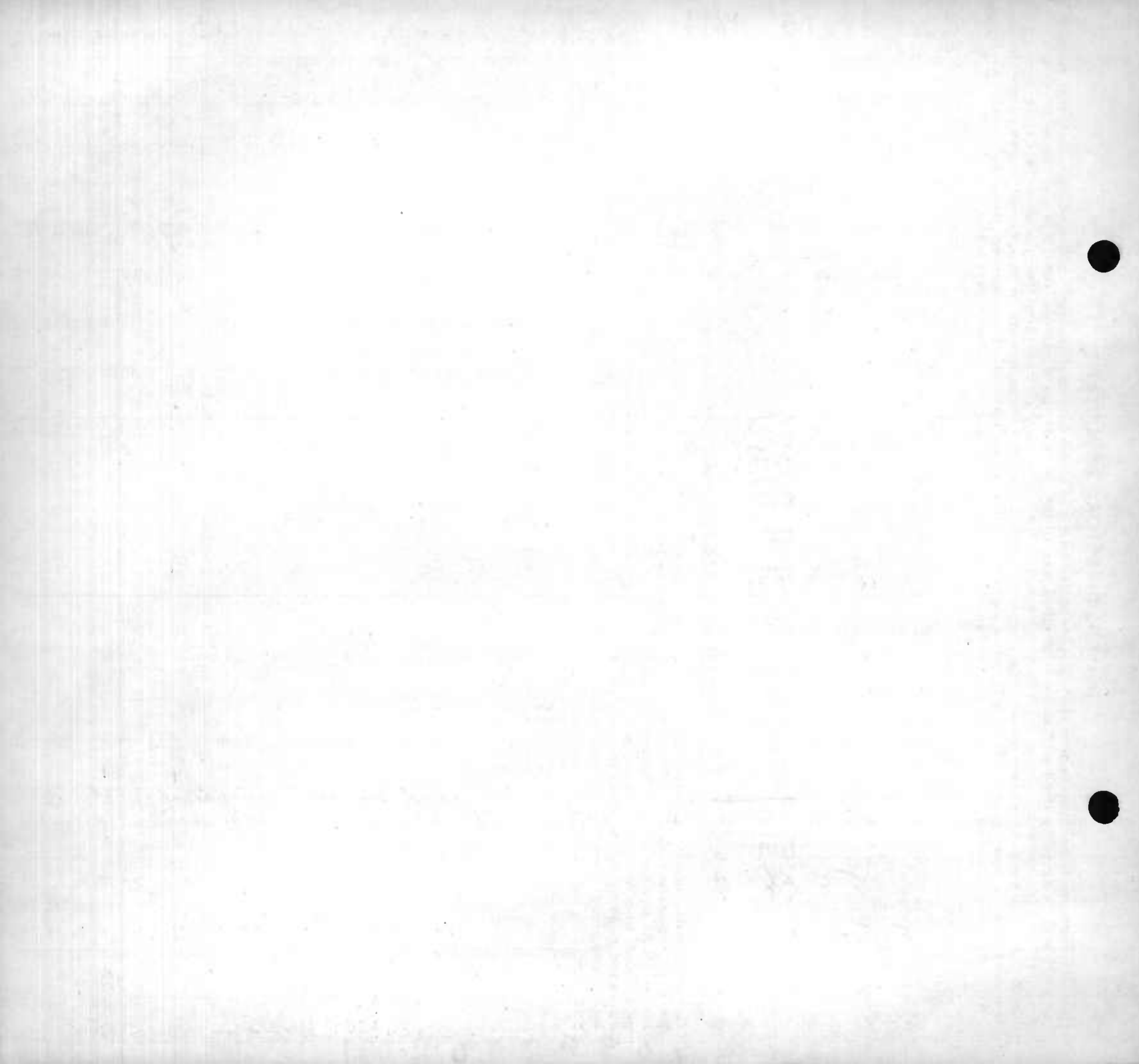
| BIRTH NO. 65 9743 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9743 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|----------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------|------------------------------------------|------------------------------------------------------------------------------|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Ethel M. Reason | | | | 2. DATE AND HOUR OF DEATH 9/20/65 14:15 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital | | | | A. STATE MARYLAND B. COUNTY 16-04 | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | | D. STREET ADDRESS (If rural, give location) 732 N. FULTON AVENUE | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 1-3-03 | 9. AGE (In years last birthday) 62 | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10B. KIND OF BUSINESS OR INDUSTRY Put Farming | | 11. BIRTHPLACE (State or foreign country) Westmoreland Co Pa | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JOHN GILLISON | | | | 14. MOTHER'S MAIDEN NAME VIRGINIA BROOKS | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 21-33-624 | | 17. INFORMANT Josephine Vaughan 732 N FULTON Ave. | |
| 18. 199-21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIAC Arrest | | | | INTERVAL BETWEEN ONSET AND DEATH 20 min. | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Peritonitis | | | | ? 4-5 days | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Carcinoma ? Uterus ? Colon | | | | ? 5-6 months | | | |
| 19A. DATE OF OPERATION 3/9/20/65 | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Peritonitis | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO. | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/19 1965 to 9/20 1965, that (I) (we) last saw the deceased alive on 9/20 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Robert A. Ratcherson M.D. | | | | 23B. DATE SIGNED 9/20/65 | | 23C. PHYSICIAN'S NAME (Type) ROBERT A. RATCHERSON M.D. | |
| 23D. ADDRESS Johns Hopkins Hospital | | | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | |
| 24B. DATE 9/25/65 | | | | 24C. NAME OF CEMETERY or CREMATORY Mt Auburn | | 24D. LOCATION (City, town, or county) (State) Baltimore | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 22 1965 | | | | 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR ADDRESS | |
| | | | | 25D. NAME OF REGISTRAR | | 25E. FUNERAL DIRECTOR ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

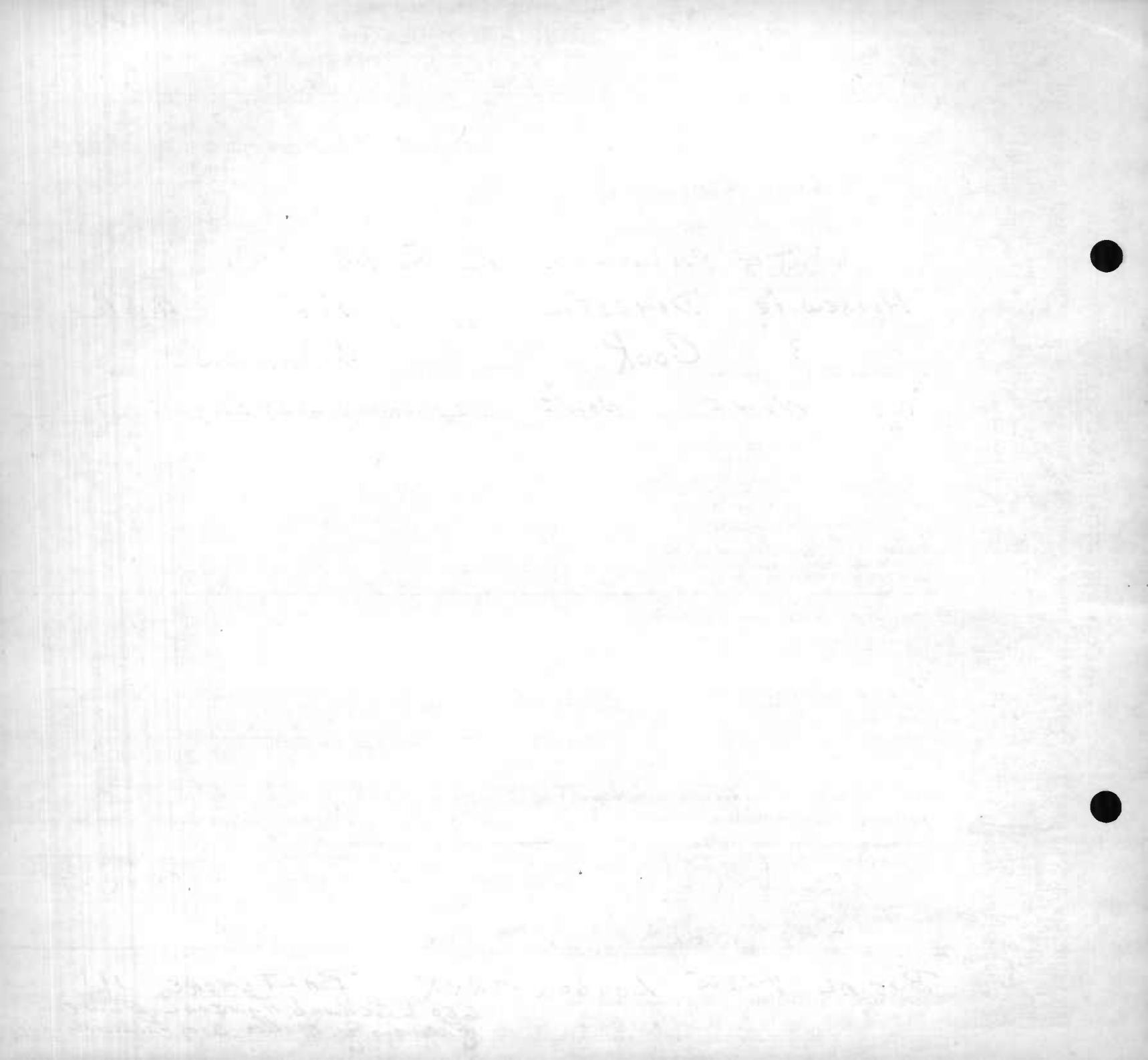
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------|----------------------------------------------------------------------|--|
| BIRTH NO. 65 9744 | | | | | Registered No. 65 9744 | | | | |
| M.E. CASE NO. | | | | | CERTIFICATE OF DEATH | | | | |
| 1. NAME OF DECEASED (Type or Print) Annie Porter | | | | | 2. DATE AND HOUR OF DEATH Sept. 20, 1965 7:00 P. M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Carver Nursing Home | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 15-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1908 N. Fulton Ave. | | | | |
| 5. SEX Female | 6. RACE Colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 8-15-1885 | 9. AGE (In years last birthday) 80 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) St. Marys Co., Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Thomas Gant | | | | | 14. MOTHER'S MAIDEN NAME Jennie Lee | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Edward Porter | | | | |
| 18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) HCVD | | | CAUSE OF DEATH (A) DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH Unknown | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Gen. Arteriosclerosis | | | (B) DUE TO | | | Unknown | | | |
| Senility | | | (C) DUE TO | | | Unknown | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from August 26, 1965 to September 20, 1965 , that (I) (we) last saw the deceased alive on September 17, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE E.E. Holt | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9/22/65 | | |
| 23C. PHYSICIAN'S NAME (Type) E.E. Holt | | | | | 23D. ADDRESS M.D. 3715 Liberty Heights Ave. Baltimore, Md. | | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 8-24-65 | | 24C. NAME OF CEMETERY or CREMATORY St. Peters Xavier Cem. | | 24D. LOCATION (City, town, or county) (State) Ridge, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 22 1965 | | 25B. NAME OF REGISTRAR Robert E. Fink | | 25C. FUNERAL DIRECTOR Elroy O. Wilson | | ADDRESS 1000 Brantley Ave. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9745 | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 65 9745 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <u>MULCARE, Florence LEE</u> | | | | 2. DATE AND HOUR OF DEATH <u>9/20/65 12:30/A.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Bou Secures Hosp.</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>28-03</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>2037 Eagle St.</u> | |
| 5. SEX <u>F</u> | 6. RACE <u>white</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>12-23-28</u> | 9. AGE (In years last birthday) <u>46</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u> | | 11. BIRTHPLACE (State or foreign country) <u>Virginia</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>J. Cook</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Un Known</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u> <u>None</u> | | | |
| 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT ADDRESS <u>Mrs. Hickman 2037 Eagle St.</u> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>420.1 I</u> <u>Acute myocardial infarction</u> | | CAUSE OF DEATH (A) DUE TO <u>Hypertension</u> (B) DUE TO <u> </u> (C) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH <u>y.</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9-20-65 @ 12:36 PM</u> to <u>9-20-65 @ 2:30 PM</u> that (I) (we) last saw the deceased alive on <u>9-20-65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Jose J. Morelos</u> M.D. | | | | 23B. DATE SIGNED <u>9/20/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Jose Morelos</u> M.D. | | | | 23D. ADDRESS <u>Bou Secures Hosp.</u> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>9-23-65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>London Park</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 22 1965</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>Geo. L. Schwab Funeral Home</u> <u>Francis G. Miller 2101 Frederick Ave</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|-------------------------------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. 65 9746 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9746 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) George Hoffman Jacobs | | 2. DATE AND HOUR OF DEATH Sept 20 1965 4:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital | | A. STATE Maryland B. COUNTY 19-04 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1822 WILKENS AVE | | | |
| 5. SEX Male | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH Aug. 4 - 1882 | 9. AGE (In years last birthday) 83 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RECEIVING CLERK | | 10B. KIND OF BUSINESS OR INDUSTRY WHOLESALE MDSE | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME Charles Jacobs | | 14. MOTHER'S MAIDEN NAME Emma Louise Seabreeze | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE | | 16. SOCIAL SECURITY NO. 213-03-5688 | | 17. INFORMANT Mrs. Day 323 W ST. N.E. Wash. DC | |
| 18. 442X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Senility | | CAUSE OF DEATH (A) Chronic Pulmonary Edema (B) Arteriosclerotic C.V.R. Disease (C) | | INTERVAL BETWEEN ONSET AND DEATH 8 mos 2 Yrs. | |
| MEDICAL CERTIFICATION | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 10 Sept 1965 to 18 Sept 1965, that (I) (we) last saw the deceased alive on 18 Sept 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE H. H. Bayliss | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 20 Sept 65 | |
| 23C. PHYSICIAN'S NAME (Type) H. H. BAYLISS | | 23D. ADDRESS M.D. 1600 WILKENS AVE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Sept 23 | | 24C. NAME OF CEMETERY OR CREMATORY St. Ignace | |
| 24D. LOCATION St. Ignace | | (City, town, or county) (State) BALTIMORE CITY MD | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 22 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor M.D. | | 25C. FUNERAL DIRECTOR 650 L. Schwab Funeral Home Francis J. Miller 2101 Rudolph Ave | |

Chronic Pulmonary Disease
Pulmonary Tuberculosis

Exhaustion

10-10-10 10-10-10

1000 MILL KENS AVE

H. H. BAYLOR
H. H. BAYLOR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9747 | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------|------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|
| BIRTH NO. | | M.E. CASE NO. | | <div style="display: flex; justify-content: space-between;"> <div>CERTIFICATE OF DEATH</div> <div>9/21/65 1 3:15 P M.</div> </div> | |
| 1. NAME OF DECEASED (Type or Print) William Pickens | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL | | A. STATE MARYLAND | | | |
| | | B. COUNTY 8-06 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) 1718 N. BETHEL STREET | | | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 3-30-12 | 9. AGE (In years last birthday) 53 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co | | 11. BIRTHPLACE (State or foreign country) S. C. | |
| 13. FATHER'S NAME JAY Pickens | | 14. MOTHER'S MAIDEN NAME OLLIE MURPHY | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War II | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Jessie Pickens 1718 N. Bethel St | |
| II DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH Tuberculous peritonitis (A) DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | |
| | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/21/65 to 9/21/65 that (I) (we) lost saw the deceased alive on 9/21/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Herman K. Gold | | | | 23B. DATE SIGNED 9/21/65 | |
| 23C. PHYSICIAN'S NAME (Type) Herman K. Gold | | | | 23D. ADDRESS Johns Hopkins Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Removal 9/25/65 | | 24B. DATE 9/25/65 | | 24C. NAME of CEMETERY or CREMATORY Greenview S. C. | |
| 24D. LOCATION (City, town, or county) (State) Greenville S. C. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 23 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Walter E. Elshewer 11297 Cedar St | | | |

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FUNERAL DIRECTOR: IMPORTANT

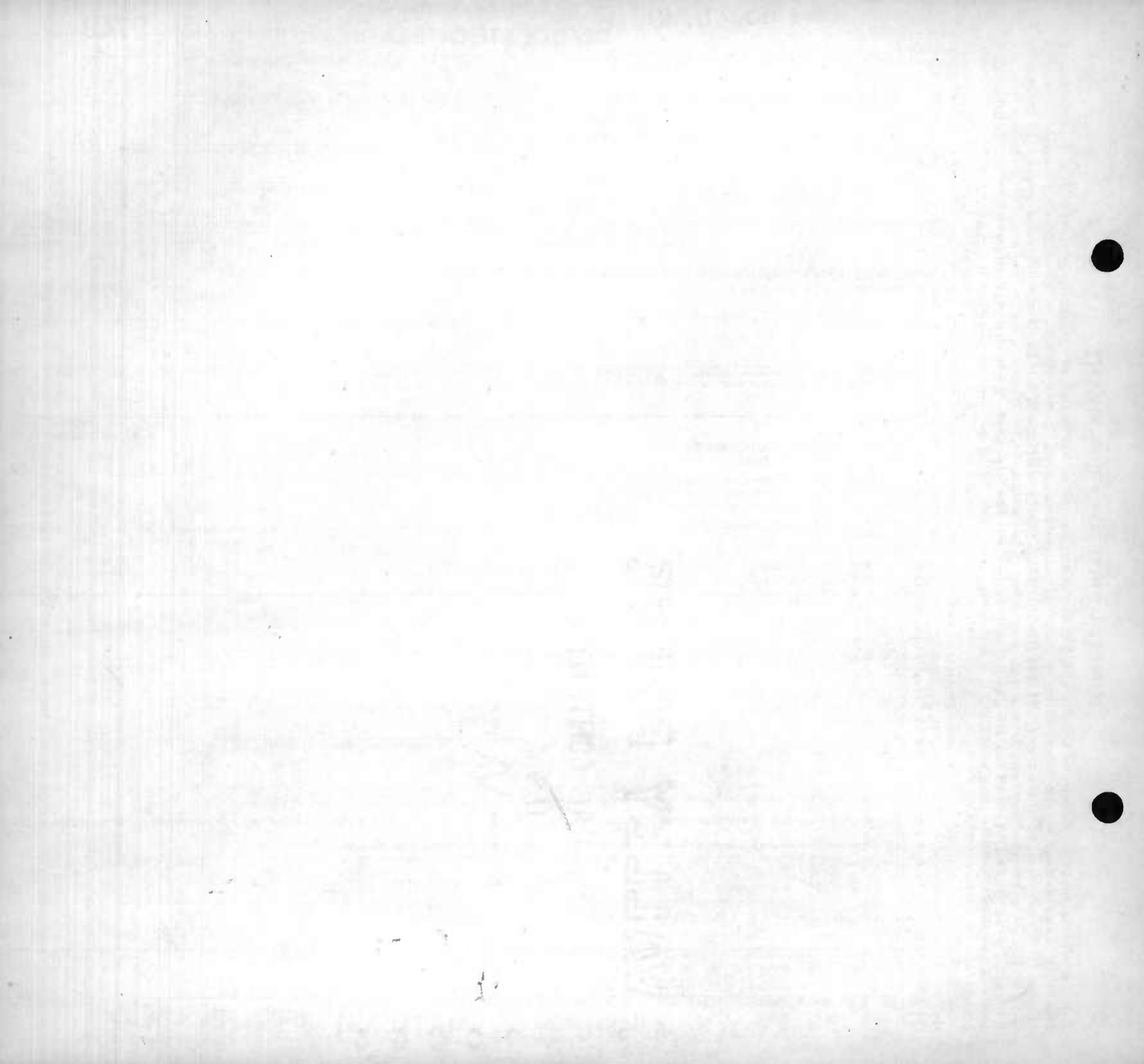
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------|--------------------------------------------------------------------------|--------------------------------------------------|
| BIRTH NO. 65-22950 65 9748 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9748 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Baby Girl McNEIL | | 9-13-65 | | 1:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE Md | | B. COUNTY | |
| UNIVERSITY HOSPITAL | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | BALTIMORE 14-3 | |
| | | D. STREET ADDRESS (If rural, give location) | | 2100 Brunt St. | |
| 5. SEX F | 6. RACE C | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 9-13-65 | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | | |
| INFANT | | MARYLAND | USA | | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| ALFORD McNEIL | | JANICE M. HICKMAN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | CHART | |
| 18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) DUE TO PREMATURITY | | INTERVAL BETWEEN ONSET AND DEATH 10 1/2 hrs. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-13-65 19 to 9-13-65 19, that (I) (we) lost saw the deceased alive on 9-13-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| CARLOS ABEL | | | | 9-13-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| CARLOS ABEL | | University Hospital - | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY & CREMATORY | |
| | | SEP 20 1965 | | ANATOMY BOARD OF MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR'S ADDRESS | |
| SEP 23 1965 | | UNIVERSITY MEDICAL SCHOOL | | MORTUARY SERVICE - BCHD | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

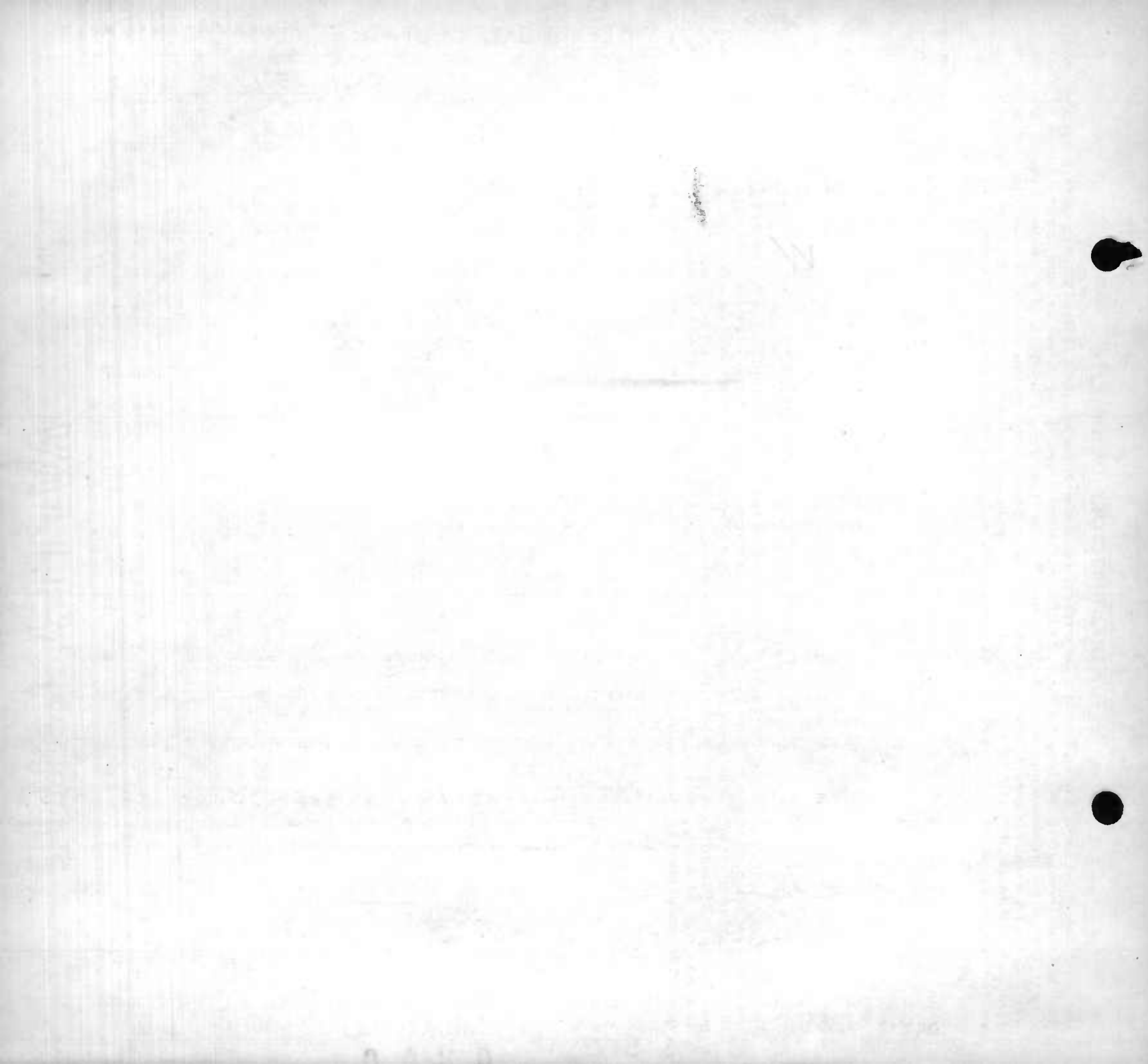
| | | | |
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| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9749 | |
| BIRTH NO. 65-21543 65 9749 | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) Baby Boy Diggs | | 2. DATE AND HOUR OF DEATH 8-25-65 1:40 a. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION University | | A. STATE MD B. COUNTY 15-09 | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| 5. SEX Male | | D. STREET ADDRESS (If rural, give location) #124 Fairview Terrace Ave. | |
| 6. RACE Colored | | E. DATE OF BIRTH 8-25-65 | |
| 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 9. AGE (In years lost birthday) 7 m. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) University Hosp. ER | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME ? | | 14. MOTHER'S MAIDEN NAME Ruby Diggs | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT | | ADDRESS | |
| 18. 776 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Imaturity | | CAUSE OF DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO (B) DUE TO (C) DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) | |
| 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| 21G. While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 22. I certify that (I) (this hospital) attended the deceased from Aug. 25 19 65 to Aug. 28 19 65 , that (I) (we) last saw the deceased alive on Aug. 25 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | |
| 23A. SIGNATURE Grace Synges | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) GRACE SYNGES | | 23D. ADDRESS University Hospital of Ind. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE SEP 20 1965 | |
| 24C. NAME OF CEMETERY | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 23 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR | | 25D. ADDRESS MORTUARY SERVICE - BCHD | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

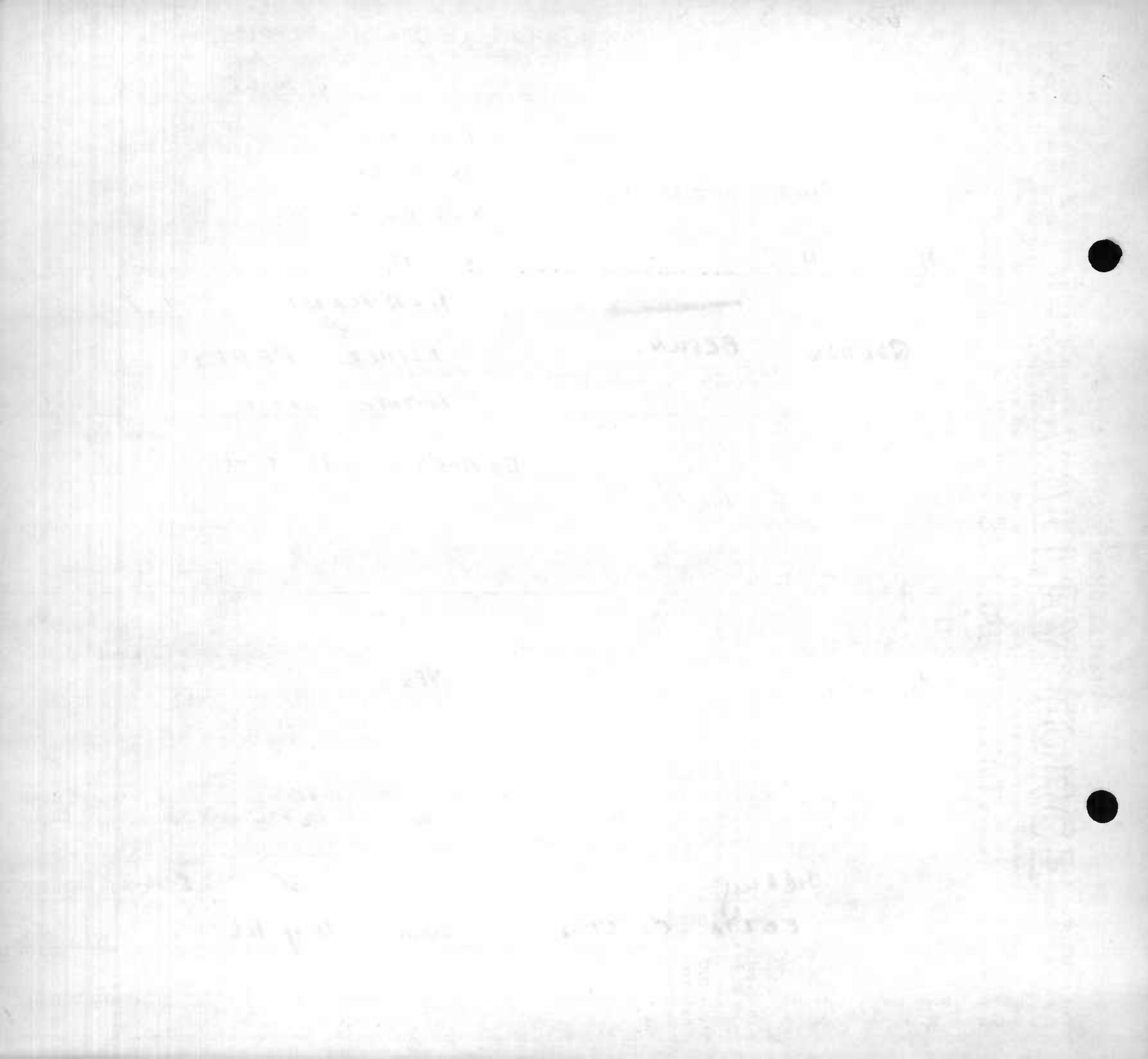
| BIRTH NO. 65 9750 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 9750 | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------|------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------------------------|-------------------------|---------------------------------------------------------|--|
| 1. NAME OF DECEASED (Type or Print) <u>Harris Baby boy</u> | | | | 2. DATE AND HOUR OF DEATH <u>Sept 15, 1965</u> <u>9:25</u> P.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Sinai Hospital of Balt., Inc.</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>207 Southenly Rd</u> | | | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never Married</u> | 8. DATE OF BIRTH <u>Sept 15, '65</u> | 9. AGE (In years last birthday) <u>2</u> | If Under 1 Yr. Months Days <u>2</u> <u>35</u> | If Under 24 Hrs. Hours Min. <u>35</u> | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>James Harris</u> | | | 14. MOTHER'S MAIDEN NAME <u>Ella Spinks</u> | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Mother</u> | | ADDRESS <u>above</u> | | |
| 18. <u>763.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) <u>Probable Aspiration Pneumonitis</u> DUE TO (B) <u></u> DUE TO (C) <u></u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs 35 min</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/> Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (this hospital) attended the deceased from <u>Sept 15, 1965</u> to <u>Sept 15, 1965</u> , that (we) lost saw the deceased alive on <u>Sept 15, 1965</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (view) the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>C. C. Haydel, Jr.</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>Sept 15, '65</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>C. C. HAYDEL, JR.</u> | | | | 23D. ADDRESS <u>Sinai Hosp of Balt, Inc.</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>SEP 21 1965</u> | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY <u>ANATOMY BOARD OF MARYLAND</u> | | 24D. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 23 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Farkner</u> | | 25C. FUNERAL DIRECTOR <u>UNIVERSITY MEDICAL SCHOOL</u> | | ADDRESS <u>MORTUARY SERVICE - BCHD</u> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

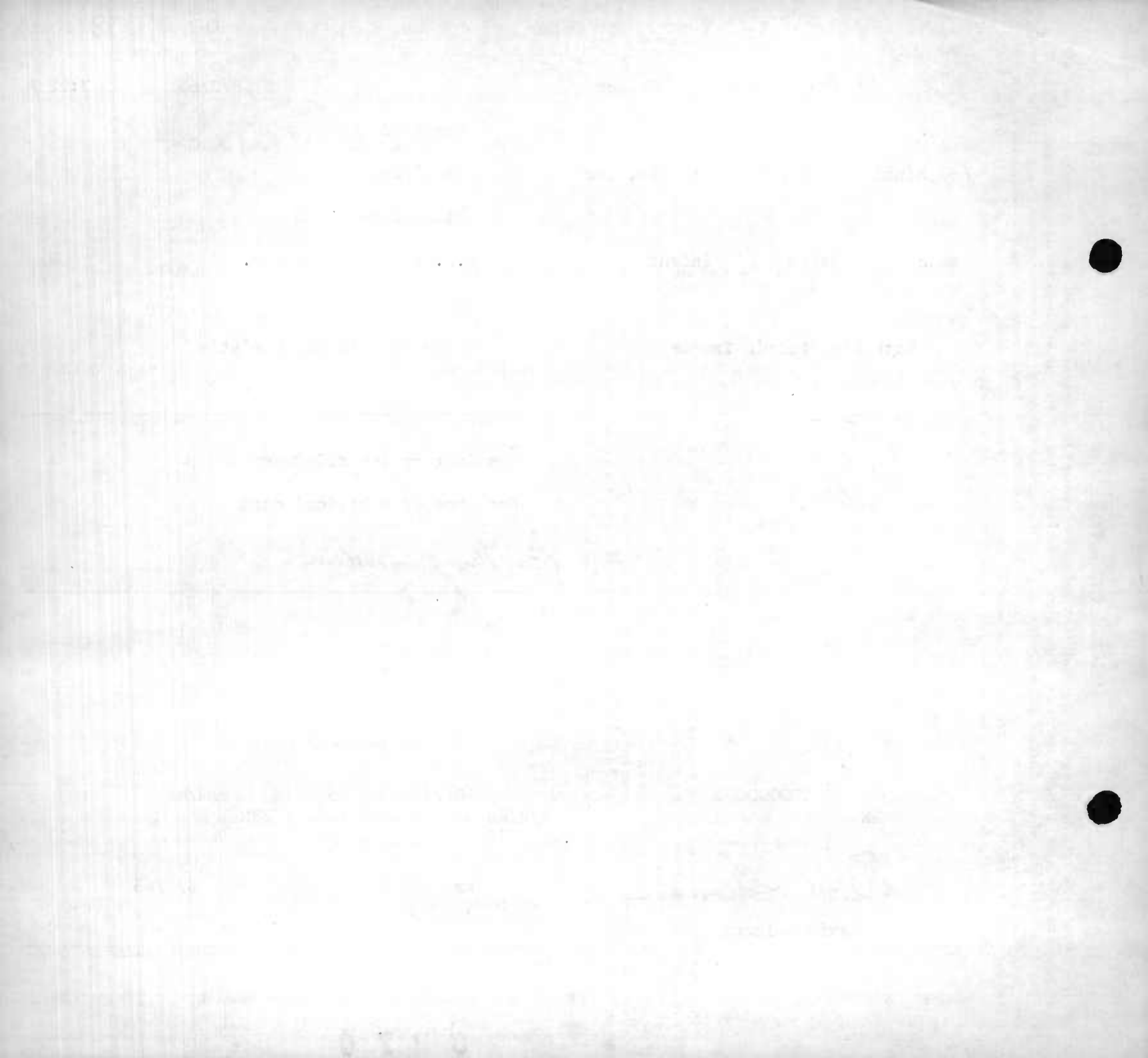
| Baltimore City Health Department | | | | Registered No. | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------|
| BIRTH NO. 65-19752 65 9751 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | | DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) BABY BOY BROWN | | | 8-10-65 6:15 M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL | | | A. STATE MARYLAND B. COUNTY BALTIMORE | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | |
| | | | D. STREET ADDRESS (If rural, give location) 824 Maryland Ct. | | |
| 5. SEX M | 6. RACE N | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 8-9-65 | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME GORDON BROWN | | | 14. MOTHER'S MAIDEN NAME ESTHER PERRY | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS MOTHER - SAME | |
| 18. 770.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ERYTHROBLASTOSIS FETALIS | | | INTERVAL BETWEEN ONSET AND DEATH 6 hrs. | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-9-65 to 8-10-65 , that (I) (we) last saw the deceased alive on 8-10-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE George | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 8-10-65 |
| 23C. PHYSICIAN'S NAME (Type) EDITHA C. CRUZ | | | 23D. ADDRESS Sinai Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) SEP 21 1965 | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY ANATOMY BOARD OF MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 23 1965 | | 25B. NAME OF REGISTRAR Robert E. Faldut | | 25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHO | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 19899 65 9752 | | | | Baltimore City Health Department | | Registered No. 65 9752 | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|----------------------------------------------------------------------|--|
| 1. NAME OF DECEASED (Type or Print) Baby Boy Trader | | | | 2. DATE AND HOUR OF DEATH 8/2/65 7:22 A. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital of Baltimore, Inc | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 310 A Suter Road | | | |
| 5. SEX male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) infant | 8. DATE OF BIRTH 8.2.65 | 9. AGE (In years last birthday) 9 min. | If Under 1 Yr. Months: Days: Hours: Min. 9 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | 13. FATHER'S NAME Nathaniel Melvin Trader | | | | |
| 14. MOTHER'S MAIDEN NAME Swendolyn Alethia Christie | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Respiratory Insufficiency ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Prolapse of umbilical cord Breech presentation | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) was XXXXXX attended the deceased from 8/2/65 19 to 8/2/65 19, that (I) was XXXX last saw the deceased alive on 8/2/65 19, and that in (my) own XXXX opinion death occurred on the date and hour and from the causes stated above. (I) was XXXXXX view the body after death. | | | | | | | |
| 23A. SIGNATURE David Solomon | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 8/6/65 | |
| 23C. PHYSICIAN'S NAME (Type) David Solomon | | | | 23D. ADDRESS 2525 Outaw Place (17) | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) SEP 21 1965 | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY ANATOMY BOARD OF MARYLAND | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 23 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCD | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

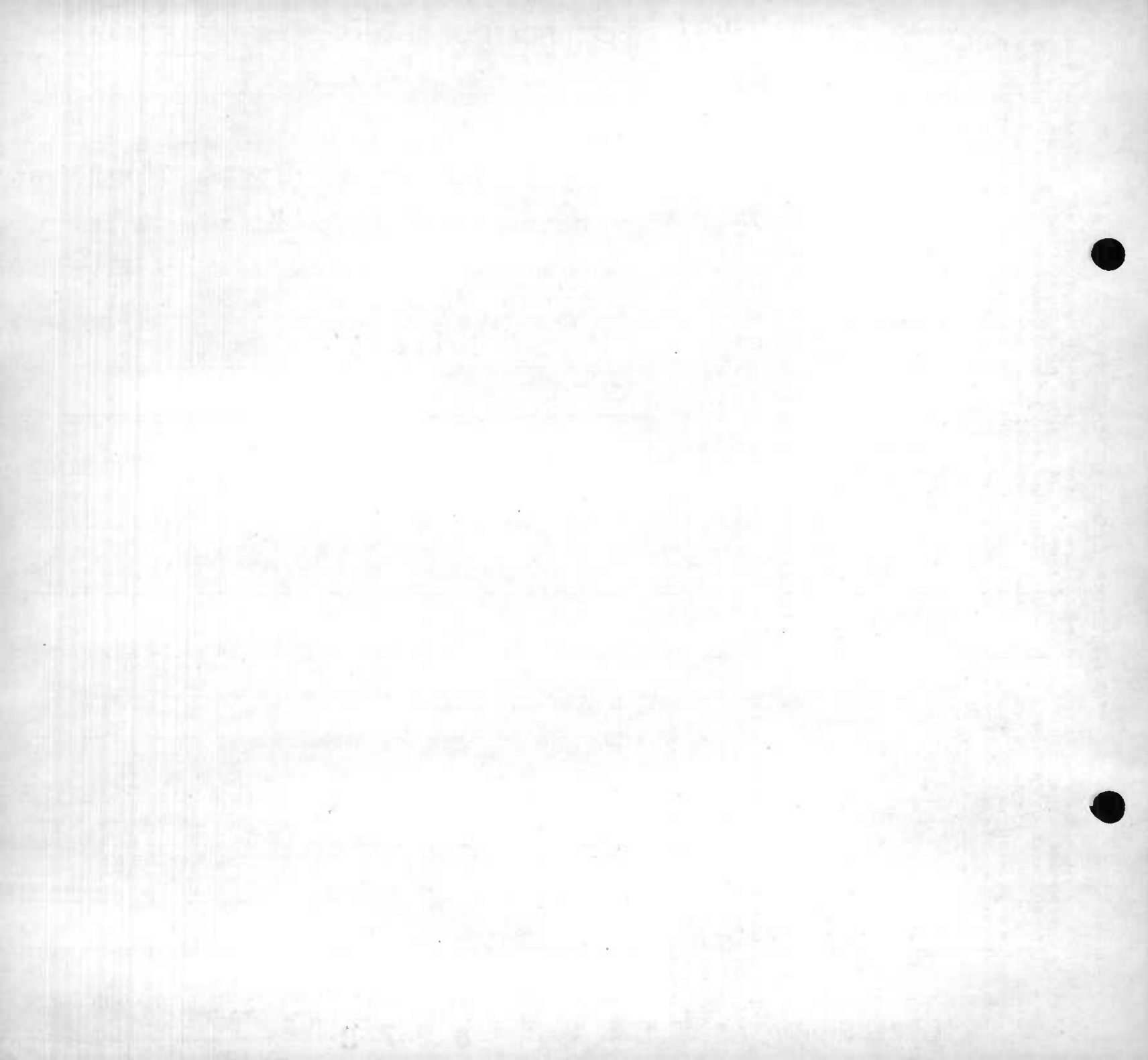
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------------------------------|
| BIRTH NO. 05-13725 65 9753 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9753 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MARTIN, Baby Boy | | 2. DATE AND HOUR OF DEATH 9/16/65 5:40 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 22 6300 | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALT. | | D. STREET ADDRESS (If rural, give location) 3429 Sollers Pt. Rd. | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never married | 8. DATE OF BIRTH 9/16/65 | 9. AGE (In years lost birthday) — | If Under 1 Yr. Months: Days: Hours: Min. 7 10 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant. | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME WESLEY MARTIN | | 14. MOTHER'S MAIDEN NAME LORETTA BRIANT | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Father | |
| 18. 763.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pneumonia | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 76 hrs. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that he (this hospital) attended the deceased from 9/16 19 65 to 9/16 19 65 , that he (we) last saw the deceased alive on 9/16 19 65 and that my (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) did not view the body after death. | | | |
| 23A. SIGNATURE Barbara C. Wagner | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/16/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS SINAI HOSPITAL BALTIMORE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE SEP 21 1965 | | 24C. NAME OF CEMETERY ANATOMY BOARD OF MARYLAND | |
| 24D. LOCATION (City, town, or county) | | 24E. STATE (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 23 1965 | | 25B. NAME OF REGISTRAR Robert E. Fairbank | | 25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD | |
| 25D. ADDRESS | | 25E. ADDRESS | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

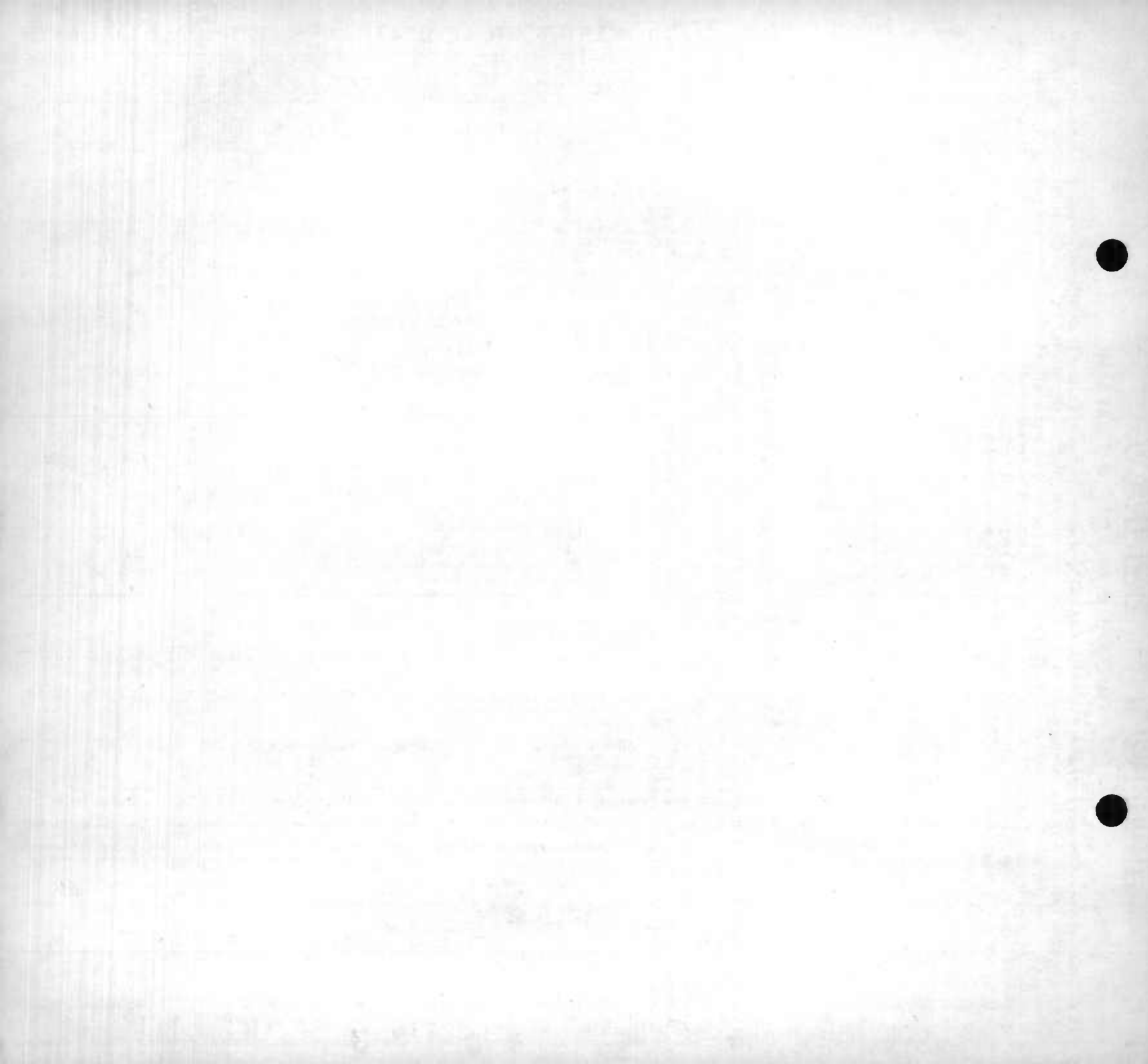
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| BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9754 | |
| BIRTH NO. 65-119265 9754 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 2. DATE AND HOUR OF DEATH 9-1-65 7 A.M. | |
| 1. NAME OF DECEASED (Type or Print) BABY GRL SPEAS. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD 8. COUNTY 99 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2 SINAI HOSPITAL | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) LAUREL ACRES, PASADENA D. STREET ADDRESS (If rural, give location) LAUREL DRIVE 32-00 | |
| 5. SEX F | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH 8-31-65 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) 25 |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME WILLIAM. Speas | | 14. MOTHER'S MAIDEN NAME Irene Koc | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
| 18. 773.51 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) PREMATURITY ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, Hyaline Mem. Disease | | INTERVAL BETWEEN ONSET AND DEATH 25 Hrs. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/31/65 19 to 9/1/65 19, that (I) (we) last saw the deceased alive on 9/1/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Sidney Seidman | | 23B. DATE SIGNED 9/1/65 | |
| 23C. PHYSICIAN'S NAME (Type) SIDNEY SEIDMAN | | 23D. ADDRESS ANATOMY BOARD OF MARYLAND | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) SEP 21 1965 | | 24B. DATE | |
| 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 23 1965 | | 25B. NAME OF REGISTRAR | |
| 25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

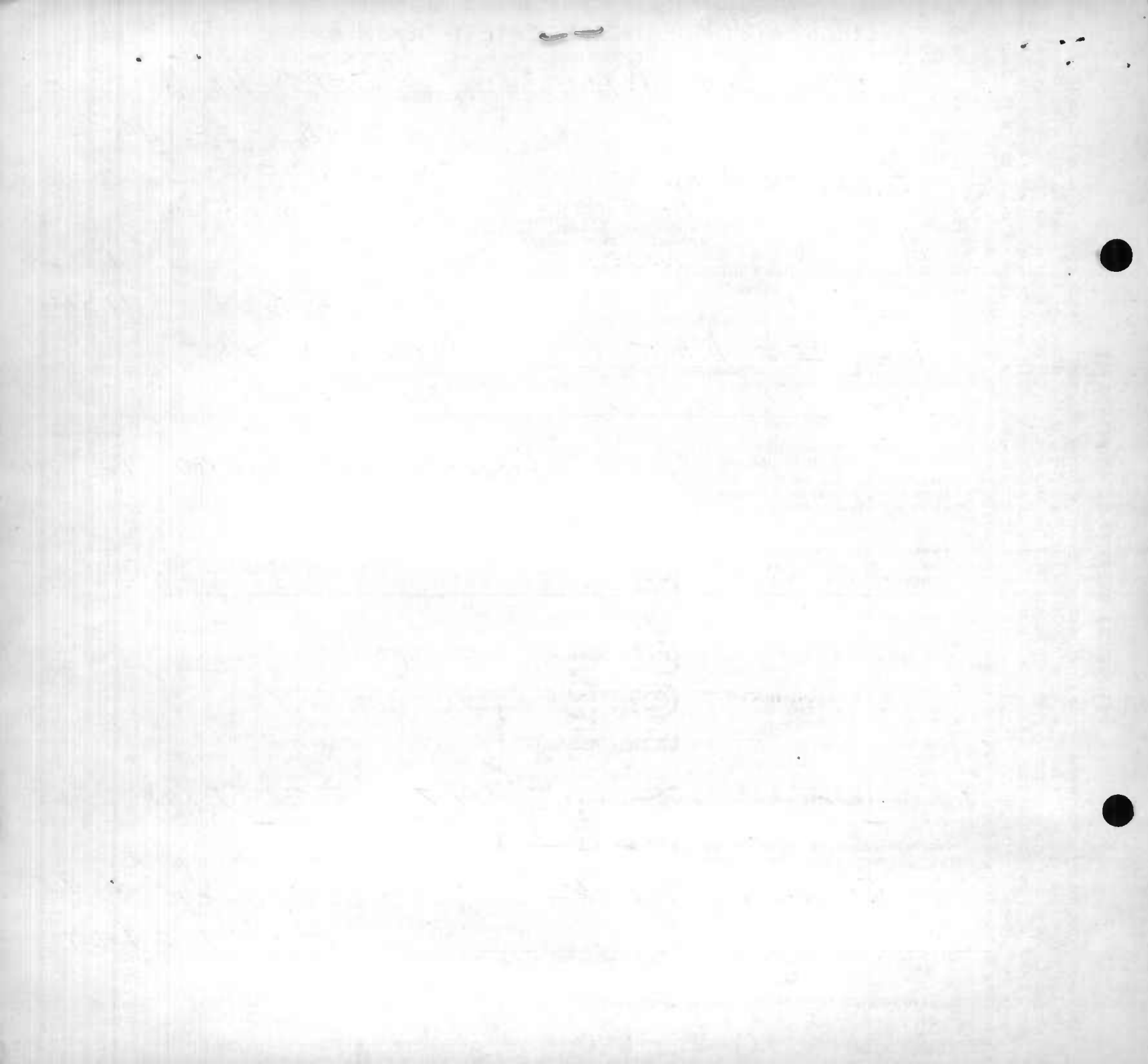
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|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|------------------------------------------------------------------------------------------------|----------------------------------------------------------------|
| BIRTH NO. <u>65-2269665</u> <u>9755</u> | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. <u>65</u> <u>9755</u> <u>x</u> | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>DORSEY, BABY GIRL</u> | | 2. DATE AND HOUR OF DEATH <u>SEPT 8, 1965</u> <u>2:50</u> <u>A.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>SINAI Hospital OF BALT, Inc</u> | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> <u>16-05</u> D. STREET ADDRESS (If rural, give location) <u>2538 Riggs Ave</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>N</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEVER MARRIED</u> | 8. DATE OF BIRTH <u>SEPT 8, '65</u> | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days: Hours: Min. <u>1</u> <u>10</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>Joseph Dorsey</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Wilson</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. <u>762.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) <u>PRIMARY</u> <u>APNEA</u> DUE TO (B) _____ DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>1 hr 10 min</u> | |
| MEDICAL CERTIFICATION | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) <u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (this hospital) attended the deceased from <u>SEPT 8</u> 19 <u>65</u> to <u>SEPT 8</u> 19 <u>65</u> , that (we) last saw the deceased alive on <u>SEPT 8</u> 19 <u>65</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>C. C. Haydel, Jr.</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED <u>Sept 8, 65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>C. C. HAYDEL, JR.</u> | | 23D. ADDRESS <u>SINAI HOSP OF BALT. INC.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>SEP 21 1965</u> | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY <u>UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

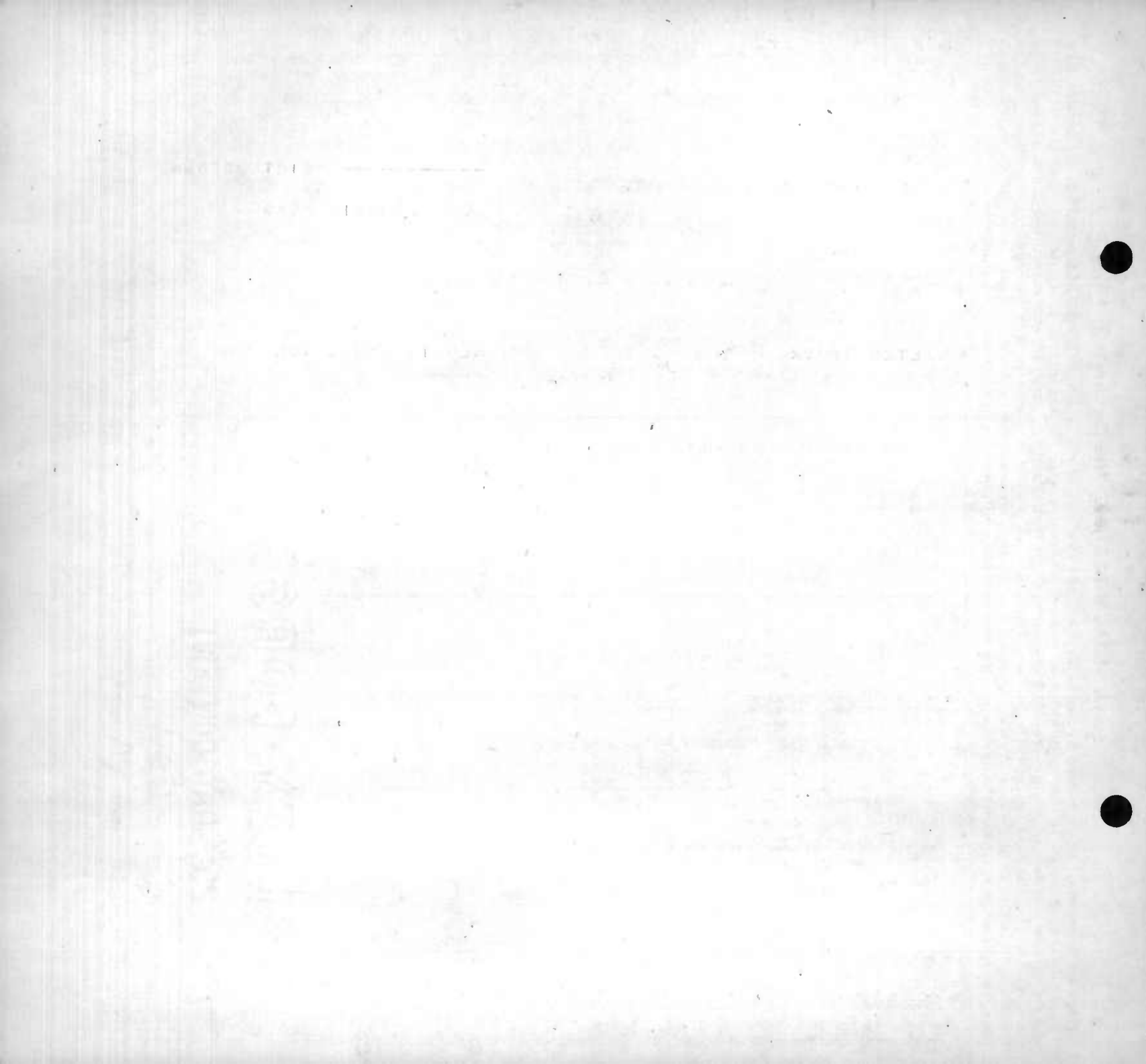
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| BIRTH NO. 65-2320265 | | 9756 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9756 | |
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) BABY BOY NASIT | | | |
| 2. DATE AND HOUR OF DEATH SEPT 18 65 7 A.M. | | | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) SYKEVILLE Carroll | | | |
| D. STREET ADDRESS (If rural, give location) 107 E. Hemlock Dr. 56-00 | | | | FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL OF BALTIMORE | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER | | 8. DATE OF BIRTH SEPT 17 | 9. AGE (In years last birthday) 12 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 12 20 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME DALE LEE NASIT | | | | 14. MOTHER'S MAIDEN NAME NANCY RUPERT | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. no | | 17. INFORMANT hosp. records | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ENCEPHALOCLE - RUPTURED | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH 12 20 hrs. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO | | (B) DUE TO | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | (C) DUE TO | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that at (this hospital) attended the deceased from 9/17 19 65 to 9/18 19 65 , that (I) was last saw the deceased alive on 9/17 19 65 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death. | | | | | | | |
| 23A. SIGNATURE Barbara C. Wagner M.D. | | | | 23B. DATE SIGNED Sept 18, 1965 | | 23C. PHYSICIAN'S NAME (Type) | |
| 23D. ADDRESS Sinai Hospital of BALT. | | | | 23E. FUNERAL DIRECTOR | | ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) SEP 21 1965 | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 23 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT 117-2720 NS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. <u>65-23614 9757</u> | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. <u>65 9757</u> | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>KATHERINE JUNE OPDYKE</u> | | | 2. DATE AND HOUR OF DEATH <u>9/19/65</u> <u>4:40 P.</u> M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>JOHNS HOPKINS HOSPITAL</u> | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE REISTERSTOWN</u> D. STREET ADDRESS (If rural, give location) <u>808 SUBURBIA ROAD</u> | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>NEWBORN</u> | 8. DATE OF BIRTH <u>9/19/65</u> | 9. AGE (In years last birthday) <u>8</u> | If Under 1 Yr. Months: <u>8</u> Days: <u>10</u> If Under 24 Hrs. Hours: <u>10</u> Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NEWBORN</u> | | | 11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>WALTER OPDYKE</u> | | | 14. MOTHER'S MAIDEN NAME <u>GLORIA CONGLETON</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| 18. <u>774 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) <u>Cardio-vascular/resp arrest</u> DUE TO (B) <u>Hyaline Membrane Disease</u> DUE TO (C) <u>Prematurity</u> | | INTERVAL BETWEEN ONSET AND DEATH |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>2 NO</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>9/19</u> 19 <u>65</u> to <u>9/19</u> 19 <u>65</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>9/19</u> 19 <u>65</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Harriet W. Coussons</u> | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>9/19/65</u> |
| 23C. PHYSICIAN'S NAME (Type) <u>HARRIET W. COUSSONS</u> | | | 23D. ADDRESS M.D. <u>JOHNS HOPKINS HOSPITAL</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u> | 24B. DATE <u>9/20/65</u> | 24C. NAME OF CEMETERY or CREMATORY <u>The Johns Hopkins Hospital</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 23 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Farber</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>HOSPITAL DISPOSAL</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9758 | |
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| BIRTH NO. 65 9758 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) ROSA LA RUE | | 2. DATE AND HOUR OF DEATH 9-19-65 4:55 P.M. | |
| 3. PLACE OF DEATH BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | |
| FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL | | D. STREET ADDRESS (If rural, give location) 755 W. LEXINGTON ST. | | E. AGE (In years lost birthday) 79 | |
| 5. SEX FEMALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 6-6-86 | 9. AGE (In years lost birthday) 79 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Raleigh N.C. | |
| 13. FATHER'S NAME HENRY ZORA | | 14. MOTHER'S MAIDEN NAME MARGARET RAY | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Vernon LaRue 3307 Powhatan Ave. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 422.1 I ASCVD & renal failure | | CAUSE OF DEATH (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 30 YRS | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| (C) DUE TO | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/17 19 65 to 9/19 19 65 , that (I) (we) last saw the deceased alive on 9/19/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J.R. Spencer | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9/19/65 | |
| 23C. PHYSICIAN'S NAME (Type) J. R. SPENCER | | 23D. ADDRESS JOHNS HOPKINS HOSP. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/20/65 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem. | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 23 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor M.D. | |
| 25C. FUNERAL DIRECTOR Williams Funeral Home | | ADDRESS 319 N. Frederick St. | | | |

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Dr. R. Spencer
Dr. R. Spencer

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| 65 9759 BIRTH NO. | | CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | 65 9759 Registered No. | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Jackson, Clara | | | 2. DATE AND HOUR OF DEATH September 20, 1965 6:15 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 19-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1519 W. Lexington Street | | |
| 5. SEX Female | | 6. RACE Negro | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH 9-9-23 | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 9. AGE (In years last birthday) 42 | | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME John W. Jackson | | |
| 14. MOTHER'S MAIDEN NAME Clara Jones | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. 215-24-6326 | | 17. INFORMANT Bertrud Jackson | | ADDRESS 1519 W. Lexington St. | |
| 18. 490X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) No. | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from September 17, 1965 to September 20, 1965 , that (I) (we) last saw the deceased alive on September 20, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE  23C. PHYSICIAN'S NAME (Type) Andre Rigaud | | | | 23B. DATE SIGNED September 20, 1965 | |
| 24A. BURIAL CREMATION, REMOVAL (specify) Burial | | 24B. DATE Sept 23 1965 | | 24C. NAME OF CEMETERY or CREMATORY St. Luke's Cem. | |
| 24D. LOCATION (City, town, or county) (State) Balto. Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 23 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR Williams Funeral Home | | ADDRESS 319 N. Schroeder St. | | 25D. DATE OF DEATH SEP 20 1965 | |

FUNERAL DIRECTOR: IMPORTANT

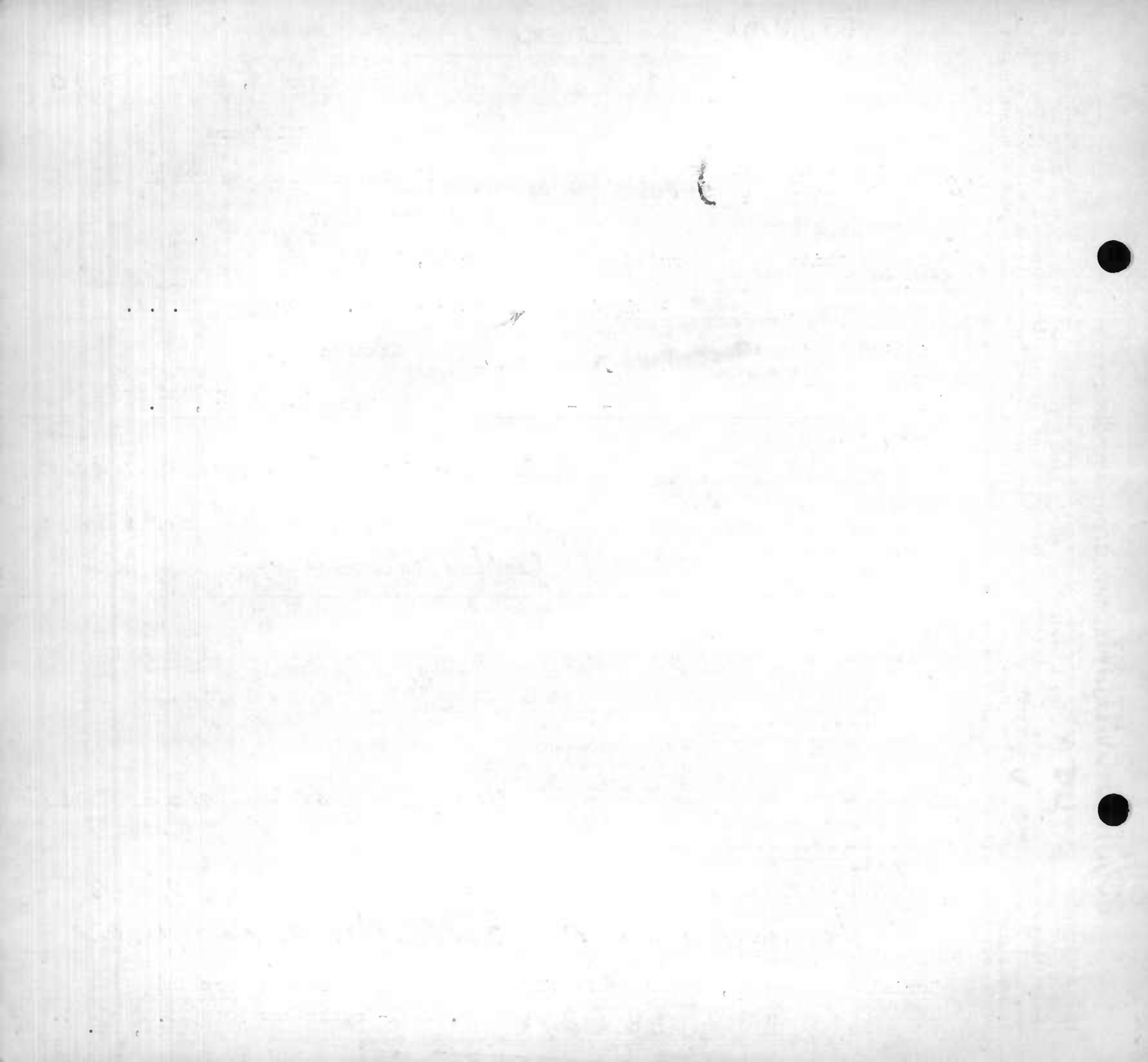
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9760 | |
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| N-63165 9760 | | | | | |
| BIRTH NO. | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) Helen E. Northup | | | 2. DATE AND HOUR OF DEATH September 19, 1965 12:30 P. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland, Baltimore B. COUNTY Baltimore | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland, #21224 | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Rural | | |
| | | | D. STREET ADDRESS (If rural, give location) 7291 Holabird Avenue, #21222 | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH April 3, 1894 | 9. AGE (In years last birthday) 71 | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) Anne Arundel County Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Thomas Wade | | | 14. MOTHER'S MAIDEN NAME Emma Jones | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT RECORDS: BCH, 4940 Eastern Avenue, #21224 |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonia | | | INTERVAL BETWEEN ONSET AND DEATH 4 Days | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) Metastatic Carcinoma of Breast 5 Years | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None | | | | | |
| 19A. DATE OF OPERATION 2 7/6/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED (Biopsy) Metastasis | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from June 19, 1965 to September 19, 1965 , that (I) (we) last saw the deceased alive on September 19, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE W. R. Hale | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/19/65 |
| 23C. PHYSICIAN'S NAME (Type) DR. W. R. HALE | | | 23D. ADDRESS 4940 Eastern Avenue, Balto., Md., #21224 | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) Burial | 24B. DATE 9/22/65 | 24C. NAME of CEMETERY or CREMATORY Cedar Hill Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 23 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Inc. 1217 St. Paul St. 21202 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| B-6561 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9761 | |
| BIRTH NO. 65 9761 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) JOHN BRAINARD | | 2. DATE AND HOUR OF DEATH September 20, 1965 3:59 a.m. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lake Drive Nursing Home 2401 Eutaw | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | D. STREET ADDRESS (If rural, give location) 2025 Maryland Ave | |
| 5. SEX Male | 6. RACE White | 7. MARRIED; NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Mar 15, 1887 | 9. AGE (In years last birthday) 78 | 10. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | 10B. KIND OF BUSINESS OR INDUSTRY Retired | | 11. BIRTHPLACE (State or foreign country) Lawrence Co. Kentucky | |
| 13. FATHER'S NAME William Brainard | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 278-05-2296 | | 17. INFORMANT Eugene Brainard 2025 Maryland Ave Baltimore, Md. | |
| 18. 332X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Cerebrovascular Thrombosis DUE TO (B) Cerebrovascular Art. scl. DUE TO (C) Gen'l. Arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH several days sev. hrs. years | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II | | none | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/23 1965 to 9/20 1965, that (I) (we) last saw the deceased alive on 9/19 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Louis V. Blum, M.D. | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9/20/65 | |
| 23C. PHYSICIAN'S NAME (Type) Louis V. Blum, M.D. | | 23D. ADDRESS 3205 W. Rogers Ave Balto. 15, Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Sep 22, 1965 | | 24C. NAME OF CEMETERY or CREMATORY Prospect Hill | |
| | | | | 24D. LOCATION (City, town, or county) (State) Towson Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 23 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Wm. Cook-Brooks Inc 1217 St. Paul St. Baltimore, Md. | |



65 9762

BALTIMORE CITY HEALTH DEPARTMENT

65 9762

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

SAVINO SBORDONE

2. DATE AND HOUR PRONOUNCED DEAD

September 22, 1965 1:55 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1200 Valley St.

5. SEX

6. RACE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
widowed

8. DATE OF BIRTH

July 13, 1888

9. AGE (in years
last birthday)

77

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Carpenter

10B. KIND OF BUSINESS OR INDUSTRY

Retired

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Joseph Sbordone

14. MOTHER'S MAIDEN NAME

Teresa LaCioppa

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

Mrs. Joan Laguardia

ADDRESS
8 East 83rd Street
New York, N.Y.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Cranio-cerebral injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1200 Valley St.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

9 21 65 10:50

21E. INJURY OCCURRED

WHERE AT
WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

Fell from the second floor

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type) Rudiger Breitenecker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Sept. 22, 1965

23A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

23B. DATE

Sept. 22, 65

23C. NAME of CEMETERY or CREMATORY

St. Johns Cemetery

23D. LOCATION

(City, town, or county)

(State)

Queens, New York, N.Y.

24A. DATE REC'D BY HEALTH DEPT.

SEP 23 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Wm Cook-Brooks, Inc.

ADDRESS

1217 St. Paul St.

WALLACE BOHGE

WALLACE BOHGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9763 | | CERTIFICATE OF DEATH | | Registered No. 65 9763 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) SCOTT, WALTER LEO | | | 2. DATE AND HOUR OF DEATH 9-22-65 7:31AM M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL BALTIMORE, MARYLAND 21229 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 25-31 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 4304 CEDARGARDEN ROAD | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWER | 8. DATE OF BIRTH 1-7-98 | 9. AGE (In years last birthday) 67 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Pressman | | 10B. KIND OF BUSINESS OR INDUSTRY Bartgis Bros. Box | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. A. | | | 13. FATHER'S NAME William W. Scott | | |
| 14. MOTHER'S MAIDEN NAME Margaret Kearney | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN | | |
| 16. SOCIAL SECURITY NO. 215-07-5283 | | | 17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS BALTO.29 | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Complete cardiac A-V block. Coronary insufficiency. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. A.S.C.V.D. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 9-22-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from 9-17-65 to 9-22-65 and that (X) (we) last saw the deceased alive on 9-22-65 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Raphael Marin | | | 23B. DATE SIGNED 9/22/65 | | |
| 23C. PHYSICIAN'S NAME (Type) RAPHAEL MARIN | | | 23D. ADDRESS St. Agnes Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Sept. 25, 65 | | 24C. NAME of CEMETERY or CREMATORY Loudon Park Cem. | |
| 24D. LOCATION Baltimore | | 24E. LOCATION Maryland | | 25A. DATE REC'D BY HEALTH DEPT. SEP 23 1965 | |
| 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR Wm Cook-Brooks, Inc. | | 25D. ADDRESS 1217 St. Paul St. | |

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FUNERAL DIRECTOR: IMPORTANT

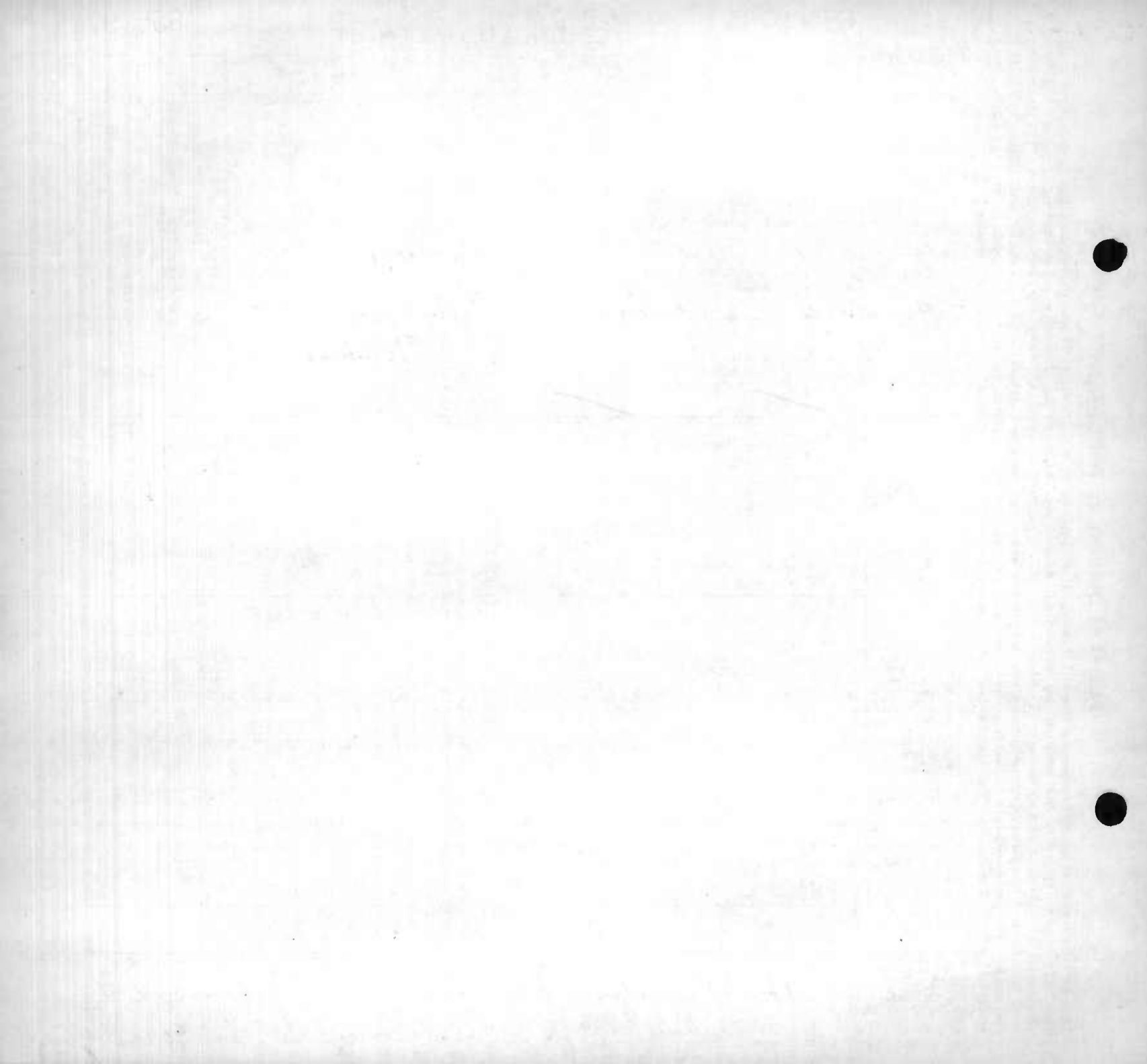
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9764 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 9764 | |
| 1. NAME OF DECEASED (Type or Print) John David Harding | | | 2. DATE AND HOUR OF DEATH 9/20/65 13:30 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital 725 North Broadway Baltimore, Md. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY ST. MARY'S CO C. CITY OR TOWN (If outside city limits, write RURAL and give township) Mechanicville, Maryland D. STREET ADDRESS (If rural, give location) 6500 | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) never married | 8. DATE OF BIRTH 10-26-50 | 9. AGE (In years last birthday) 15 years | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child | | 10B. KIND OF BUSINESS OR INDUSTRY None | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Joseph Harding | | | 14. MOTHER'S MAIDEN NAME Mary Harding | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS Mother same as # 2 above | |
| 18. 7563 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hyperbilirubinemia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cruzer Wajjar II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH (A) Hyperbilirubinemia DUE TO (B) Cruzer Wajjar DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 16 years 2 days |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from August 23 19 65 to Sept. 20 19 65 , that (I) (we) last saw the deceased alive on Sept. 20 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE S. Blumenschein | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/20/65 |
| 23C. PHYSICIAN'S NAME (Type) S. Blumenschein | | | 23D. ADDRESS The Johns Hopkins Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE Sept. 24, 1965 | 24C. NAME OF CEMETERY or CREMATORY St. Josephs | | 24D. LOCATION (City, town, or county) (State) Morganza, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 23 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR ADDRESS W. Clarke Mattingley Leonardtown, Maryland | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9765 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9765 | |
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| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) ELIZABETH CROMWELL | | | | 2. DATE AND HOUR OF DEATH SEPT. 21, 1965 2:05 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION University Hospital | | (If not in hospital or institution, give street address or location) | | A. STATE Maryland | | B. COUNTY 11-02 | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) Midtown Nursing Home 808 St Paul St. | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow | 8. DATE OF BIRTH 2/28/1891 | 9. AGE (In years last birthday) 74 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY at home | | 11. BIRTHPLACE (State or foreign country) Pittsburg, Pa. | | 12. CITIZEN OF WHAT COUNTRY? US | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Hospital Records | | ADDRESS | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute myocardial infarction 11 days | | | | (A) DUE TO | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Severe arteriosclerosis | | | | (B) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Gasping of @ foot bronchopneumonia | | | | (C) | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this <u>hospital</u>) attended the deceased from <u>Sept. 9</u> 19 <u>65</u> to <u>Sept 21</u> 19 <u>65</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>Sept 21</u> 19 <u>65</u> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>We</u>) (<u>did</u>) (<u>did not</u>) view the body after death. | | | | | | | |
| 23A. SIGNATURE BARRY N. ROSENBAUM | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/21/65 | |
| 23C. PHYSICIAN'S NAME (Type) BARRY N. ROSENBAUM | | | | 23D. ADDRESS UNIVERSITY HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/23/65 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore National | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 23 1965 | | 25B. NAME OF REGISTRAR Robert E. Farber, M.D. | | 25C. FUNERAL DIRECTOR John F. Cowen & Son, Inc. | | ADDRESS 901 Hollins St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9766 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9766 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) MARTIN, BABY BOY | | | 2. DATE AND HOUR OF DEATH 9-22-65 12:40A M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY HOWARD C. CITY OR TOWN (If outside city limits, write RURAL and give township) ELLICOTT CITY D. STREET ADDRESS (If rural, give location) 6300 FREDERICK ROAD | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED | 8. DATE OF BIRTH 9-20-65 | 9. AGE (In years last birthday) 1 | If Under 1 Yr. Months Dps 6 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME PAUL S. MARTIN | | | 14. MOTHER'S MAIDEN NAME JEAN FLEMING | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. NONE | 17. INFORMANT ADDRESS ST. AGNES RECORDS - CATON & WILKENS AVES | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Central nervous system DUE TO Anoxia (B) Pneumonia, O lung DUE TO (C) Prematurity INTERVAL BETWEEN ONSET AND DEATH 1 day 1 day 1 day | | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 20 1965 to SEPTEMBER 22 1965, that (I) (we) last saw the deceased alive on SEPTEMBER 22 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Luningning Dr. Aldaba M.D. | | | 23B. DATE SIGNED 9/22/65 | | 23C. PHYSICIAN'S NAME (Type) LUNINGNING ALDABA, MD M.D. |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-23-65 | | 24C. NAME of CEMETERY or CREMATORY GOOD SHEPHERD | |
| 24D. LOCATION (City, town, or county) (State) ELLICOTT CITY, Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 23 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | |
| 25C. FUNERAL DIRECTOR ADDRESS FCHG in BATHOM, ELLICOTT CITY Md | | | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>65 9767</u> | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. <u>65 9767</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Anderson, EARL DORSEY</u> | | 2. DATE AND HOUR OF DEATH <u>Sept. 21, 1965</u> <u>5 A. M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY HOSPITAL</u> | | A. STATE <u>MARYLAND</u> B. COUNTY <u>HOWARD</u> | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>ELlicott City</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>21 NEW COTTAGE ROAD, MARYLAND</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>Negro</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>3-11-33</u> | 9. AGE (In years last birthday) <u>32</u> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RACE HORSE GROOMER</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>HORSE RACING</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | | 13. FATHER'S NAME <u>CLARENCE E. ANDERSON</u> | | 14. MOTHER'S MAIDEN NAME <u>LILLIE DORSEY</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>MRS AGNES E. ANDERSON - WIFE</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>201X I</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) <u>Infection</u> DUE TO (B) <u>Hodgkins Disease</u> DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> <u>3 yrs.</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>2 NONE</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>YES</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12 August 19 65</u> to <u>21 SEPT 19 65</u> , that (I) (we) last saw the deceased alive on <u>21 Sept. 19 65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Richard D. Berger</u> | | M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>21 Sept 65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>RICHARD D. BERGER M.D.</u> | | 23D. ADDRESS <u>UNIVERSITY HOSPITAL</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9-24-65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Hopkins Chapel</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Highland, Howard, Md.</u> | | 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 23 1965</u> | | | |
| 25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Arthur A. Haight, Highland, Md.</u> | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9768 | | BALTIMORE CITY STATE HEALTH DEPARTMENT | | Registered No. 65 9768 | |
| M.E. CASE NO. C-240A | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) PEARL KRAKOWER | | 2. DATE AND HOUR OF DEATH 9/20/65 9:30 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 15-11 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE CITY D. STREET ADDRESS (If rural, give location) 3907 Edgewood Road | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED | 8. DATE OF BIRTH 6/21/1917 | 9. AGE (In years last birthday) 48 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME MORRIS KRAKOWER | | 14. MOTHER'S MAIDEN NAME SARAH COOK | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 220-05-8360 | | 17. INFORMANT THEODORE KRAKOWER | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, ashenia, etc. It means the disease injury or complication which caused death.) 420.1 4-153.8 Prob Ac. Coronary Thrombosis HASCVD | | CAUSE OF DEATH DUE TO DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 15 min. 5+ yrs. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CARCINOMA OF COLON | | S yrs. | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Oct 1962 to Sept 1965, that (I) (we) last saw the deceased alive on Dec 1964 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Daniel Dulac | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Sept-21, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/22/65 | | 24C. NAME OF CEMETERY or CREMATORY UNITED HEBREW INC. WASHINGTON BLVD. INC. | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE CITY MD. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 23 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley M.D. | |
| 25C. FUNERAL DIRECTOR STACK LEWIS INC. 2100 ELITAW PK | | 25D. ADDRESS BALTIMORE CITY MD. | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>65 9769</u> | |
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| BIRTH NO. <u>65 9769</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Alyce Carneal</u> | | 2. DATE AND HOUR OF DEATH <u>9/21/65</u> <u>8:20 P.M.</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>25-52</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>1105 E. Fayette Street</u> | | D. STREET ADDRESS (If rural, give location) <u>2033 Deering Avenue</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>W</u> | 8. DATE OF BIRTH <u>11/13/1881</u> | 9. AGE (in years last birthday) <u>83</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Richmond, Va.</u> | |
| 13. FATHER'S NAME <u>PORTER CALDWELL</u> | | 14. MOTHER'S MAIDEN NAME <u>NAN WILLIAMS</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>562-16-6003</u> | | 17. INFORMANT <u>Mr. Trice Porter</u> ADDRESS <u>2033 Deering Ave</u> | |
| 18. <u>443X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Heart</u> | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>several years</u> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Small cerebral degeneration</u> | | | | <u>several years</u> | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>no</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>8/12</u> 19 <u>64</u> to <u>9/21</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>9/21</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>J. Hulla</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>21 Sep 65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>J. Hulla</u> | | 23D. ADDRESS <u>2214 E Fayette St 21231</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>9/23/65</u> | | 24C. NAME of CEMETERY or CREMATORY <u>LOUDON PARK CEMETERY</u> | |
| 24D. LOCATION (City, town, or county) <u>3801 FREDERICK AVENUE, Md.</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 23 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>HUBBARD FUNERAL HOME 4107 WILKENS AVE. 29</u> | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. 65 9770 | |
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| BIRTH NO. 65 9770 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Reason, Evelyn L. (SHERIDAN)</i> | | 2. DATE AND HOUR OF DEATH <i>9/19/65 9:10 P. M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Montebello State Hospital</i> | | A. STATE <i>Maryland</i> | | <i>13-02</i> | |
| (If not in hospital or institution, give street address or location) | | B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| | | <i>Baltimore</i> | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | <i>808 Reservoir St. Apt A-1</i> | | | |
| 5. SEX <i>Female</i> | 6. RACE <i>negro</i> | 7. MARRIED, NEVER MARRIED WIDOWED, <u>DIVORCED</u> (specify) | 8. DATE OF BIRTH <i>8/6/1905</i> | 9. AGE (In years last birthday) <i>60</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House keeper</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTH PLACE (State or foreign country) <i>Maryland</i> | |
| 13. FATHER'S NAME <i>Bideaway Sheridan</i> | | 14. MOTHER'S MAIDEN NAME <i>Susie Bowen</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 15. Was Deceased Ever in U. S. Armed Services? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>216-2840189</i> | | 17. INFORMANT <i>Hospital Records</i> | |
| 18. <i>175.0</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <i>Abdominal Carcinomatosis 1 year</i> DUE TO <i>to Ascites</i> (B) <i>Probably Ovarian Carcinoma</i> DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>5/17/65</i> to <i>9/19/65</i> that (I) (we) last saw the deceased alive on <i>9/19/65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Daniel G. Lai</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>9/19/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Daniel G. Lai</i> | | M.D. 23D. ADDRESS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | 24B. DATE <i>9-23-65</i> | 24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Memorial Park</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 23 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>Charles R. Law 802 Madison Ave.</i> | |

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

Registered No. **65 9771**

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| BIRTH NO. 65 9771 | | 2. DATE AND HOUR OF DEATH 9-20-65 10:00 a.m. | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Amy D. Johnson | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 17-01 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 640 George Street | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 5-25-04 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) 61 |
| 11. BIRTHPLACE (State or foreign country) Harford Co., Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Robert Price | | 14. MOTHER'S MAIDEN NAME Marie White | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 212-36-8934 | |
| 17. INFORMANT Rudolph Johnson - 640 George Street | | ADDRESS | |
| 18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cardiac Arrhythmia ? MI ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD | | INTERVAL BETWEEN ONSET AND DEATH 10 hours many years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-14-1965 to September 20 1965 , that (I) (we) last saw the deceased alive on Sept 20 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | |
| 23A. SIGNATURE Nicholas J. Fortuin | | 23B. DATE SIGNED 9-20-65 | |
| 23C. PHYSICIAN'S NAME (Type) Nicholas J. Fortuin | | 23D. ADDRESS The Johns Hopkins Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9-24-65 | 24C. NAME of CEMETERY or CREMATORY Clarks Chapel | 24D. LOCATION (City, town, or county) (State) Harford Co., Maryland |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 23 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | |
| 25C. FUNERAL DIRECTOR Charles R. Law | | ADDRESS 802 Madison Ave. | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9772 | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 65 9772 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) William R. Jones | | | | September 20, 1965 M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital | | | | A. STATE Maryland | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| | | | | D. STREET ADDRESS (If rural, give location) 1802 N. Fulton Ave. | |
| 5. SEX M. | 6. RACE C. | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 5/10/1887 | 9. AGE (In years last birthday) 78 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY B&O Railroad | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME Moses Jones | |
| 14. MOTHER'S MAIDEN NAME Ellen Keene | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. 705-03-9047R | | | | 17. INFORMANT Estelle Jones | |
| 18. ADDRESS 1802 N. Fulton Ave. | | | | | |
| 18. CAUSE OF DEATH | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p> </div> <div style="width: 50%;"> <p>(A) Massive Pulmonary Embolus DUE TO</p> <p>(B) Phlebotrombosis - deep veins of right leg. DUE TO</p> <p>(C) Generalized Arteriosclerosis DUE TO</p> </div> <div style="width: 10%;"> <p>INTERVAL BETWEEN ONSET AND DEATH 5 minutes</p> <p>undetermined</p> <p>undetermined</p> </div> </div> | | | | | |
| 19. MEDICAL CERTIFICATION | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-9 19 65 to 9-20 19 65 , that (I) (we) last saw the deceased alive on 9-19 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE John J. Chivell | | | | 23B. DATE SIGNED 9-23-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS 1038 Edmondson Ave Baltimore Md 21223 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/26/65 | | 24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park | |
| 24D. LOCATION Arbutus, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. SEP 23 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Charles A. Rice | | | |
| 25D. ADDRESS 661 W. Barre St. | | | | | |

Massive Primary Eruptive

White Hydrothermal Deposits

Geothermal System

Yes

Yes

9-20

9-20

9-20

9-20

John A. Churchill

x

9-20

1982 Evaluation for Petroleum

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. (5) 65 9773 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9773 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|-----------------------------------------------------------------------|--------------------------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) THOMAS, HARRY NICKOLAS | | | | 2. DATE AND HOUR OF DEATH Sept. 20, 1965 10:50 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 36 FRANKLIN SQUARE HOSPITAL | | | | A. STATE MARYLAND B. COUNTY 19-03 | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 325 S. GILMORE ST. 23 | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated | 8. DATE OF BIRTH 9/26/1891 | 9. AGE (In years last birthday) 64 | If Under 1 Yr. Months: Days | | If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN - Brinton, Peck & Co. | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MD | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME RICHARD THOMAS | | | | 14. MOTHER'S MAIDEN NAME MARY DONOHUE | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 213-03-3845 | | | | 16. SOCIAL SECURITY NO. 213-03-3845 | | 17. INFORMANT ROBERT THOMAS ADDRESS BALTIMORE, MD | |
| 18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH (A) CEREBRAL HEMORRHAGE DUE TO (B) HYPERTENSION DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 4 days | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept. 17, 1965 to Sept. 20, 1965 , that (I) (we) last saw the deceased alive on Sept. 20, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Henita Suarez | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Sept. 20, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) HENITA SUAREZ | | | | 23D. ADDRESS M.D. FRANKLIN SQUARE HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/25/65 | | 24C. NAME OF CEMETERY or CREMATORY Landon | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 23 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR Witzell, 4101 Edmondson | | ADDRESS | |

SECRET

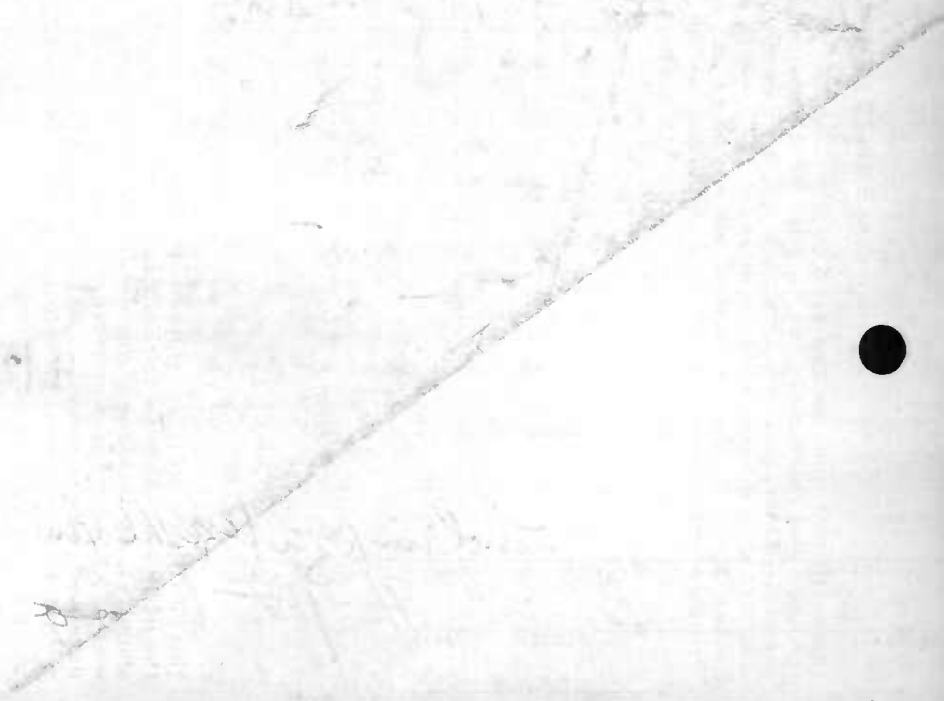
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased, prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9774 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 9774 | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------|----------------------------|-------------------------------------------------------------------------------------------|----------------------------|-----------------------------------------------------------------------------|-----------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Eugene W. Saville | | | | 2. DATE AND HOUR OF DEATH September 21, 1965 5:20 P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | BON SECOURS HOSPITAL | | A. STATE Maryland | | B. COUNTY Baltimore | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 6001 Johnnycake Rd. | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 2/8/20 | 9. AGE (In years last birthday) 45 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector | | 10B. KIND OF BUSINESS OR INDUSTRY Gen'l Motors | | 11. BIRTHPLACE (State or foreign country) West Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Ossie H. Saville | | | | 14. MOTHER'S MAIDEN NAME Mary Shank | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Margaret Saville | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 422.2 I | | | | CAUSE OF DEATH (A) Acute renal shutdown shock (B) ? Primary myocardopathy (C) | | INTERVAL BETWEEN ONSET AND DEATH 2 days 2 weeks | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) - | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) - | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) - | | | |
| 21D. TIME OF INJURY (APPROX.) - | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? - | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/4/1965 to 9/21/1965, that (I) (we) last saw the deceased alive on 9/21/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Sholam Reza Puzeshkian M.D. | | | | 23B. DATE SIGNED 9/22/1965 | | 23C. PHYSICIAN'S NAME (Type) Sholam Reza Puzeshkian | |
| 23D. ADDRESS Bon Secours Hospital | | | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | |
| 24B. DATE 9/25/65 | | 24C. NAME OF CEMETERY or CREMATORY Woodlawn | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 23 1965 | | 25B. NAME OF REGISTRAR Robert E. Jackson | | 25C. FUNERAL DIRECTOR Witko Filo | | 25D. ADDRESS 14101 Edmondson | |

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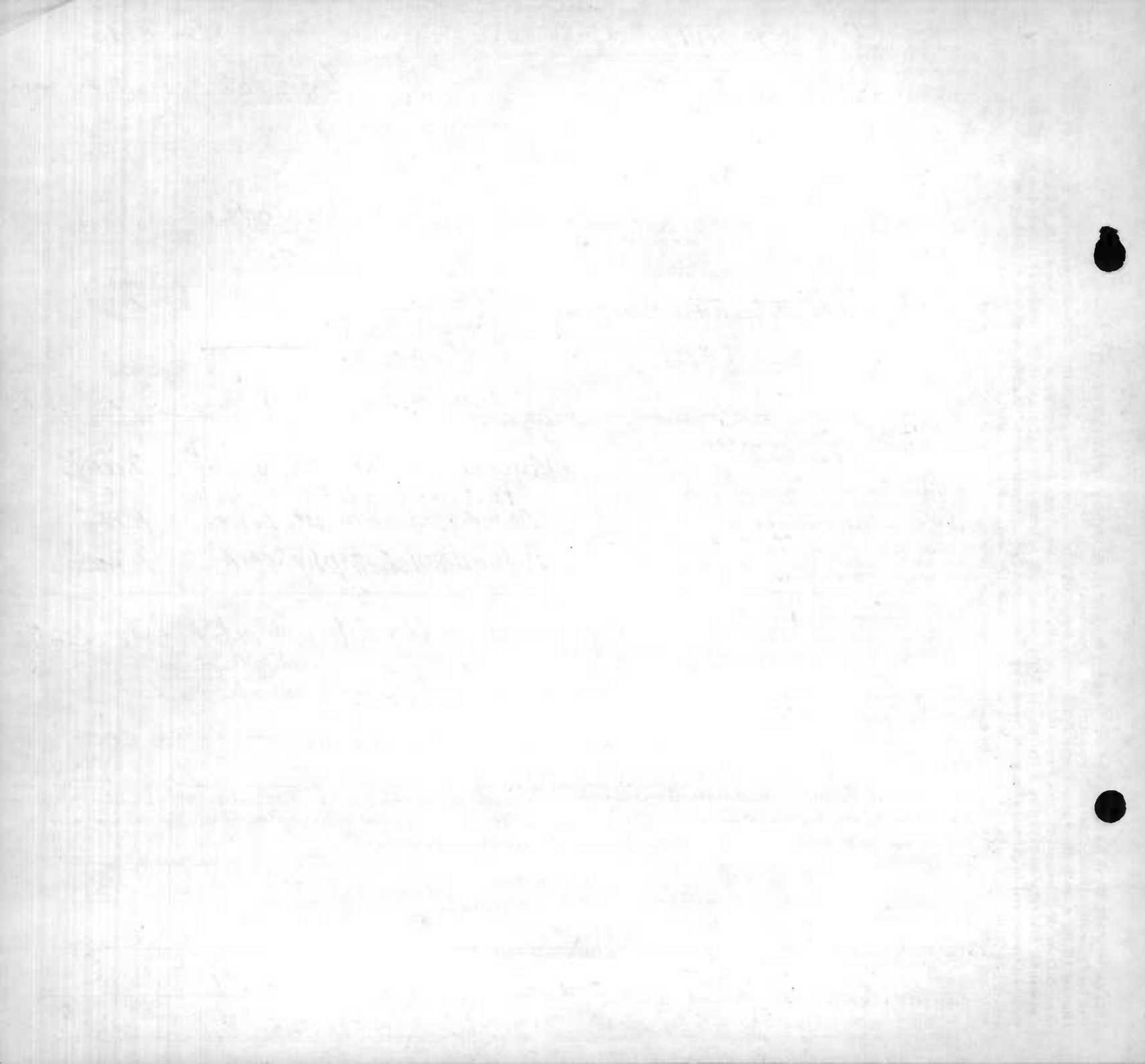
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. (4) 65 9775 | | CERTIFICATE OF DEATH | | Registered No. 65 9775 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED (Type or Print) <u>William T. Lee</u> | | | | 2. DATE AND HOUR OF DEATH <u>9/22/65</u> <u>11:20 A.M.</u> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>4 Bon Secours Hospital</u> | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>28-04</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> # <u>29</u> D. STREET ADDRESS (If rural, give location) <u>4509 Manordene Rd.</u> | | | | | |
| 5. SEX <u>M</u> | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u> | | 8. DATE OF BIRTH <u>10/26/89</u> | | 9. AGE (In years last birthday) <u>75</u> | | If Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Estimator, Plumbing</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Ind</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Andrew Lee</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Nora</u> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Mary M. Lee, 4509 Manordene Rd</u> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>420.14 1/77X</u> | | | | CAUSE OF DEATH (A) DUE TO <u>MYOCARDIAL INFARCT, RECENT</u> <u>POST. WALL OF LEFT VENTRICLE</u> (B) DUE TO <u>ARTERIOSCLEROTIC HT. DISEASE</u> (C) <u>PULMONARY EMPHYSEMA</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>years</u> <u>years</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>CARCINOMA OF PROSTATE w Metas. to Adrenals</u> | | | | <u>Months</u> | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u> | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notably medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>September 15, 1965</u> to <u>September 22, 1965</u> , that (I) (<u>we</u>) lost saw the deceased alive on <u>Sept. 22, 11:20 AM, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>we</u>) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <u>Byong Hae Kim</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED <u>Sept. 22, 1965</u> | | | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>B. H. KIM</u> M.D. | | | | 23D. ADDRESS <u>Bon Secours Hospital</u> | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9/25/65</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Woodlawn Bldg. 7. Md</u> | | 24D. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 23 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Farley</u> | | 25C. FUNERAL DIRECTOR <u>Walter W. 4101 Edmondson Ave</u> | | ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. (5) 65 9776 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9776 | |
| M.E. CASE NO. | | | 1. NAME OF DECEASED (Type or Print) DUNCAN KATE | | |
| 2. DATE AND HOUR OF DEATH 21 SEPT 65 6:15 A.M. | | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1902 | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 23 | | |
| D. STREET ADDRESS (If rural, give location) 11 N. FULTON AVE | | | FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL BALTIMORE, MD | | |
| 5. SEX F | 6. RACE Cauc | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 3-18-82 | 9. AGE (In years lost birthday) 83 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | | 10B. KIND OF BUSINESS OR INDUSTRY None | | |
| 11. BIRTHPLACE (State or foreign country) BALTIMORE | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME WM. D. RUST | | | 14. MOTHER'S MAIDEN NAME MARY SHANG | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Leon Howard, Son of Linthicum |
| 18. 170X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | CAUSE OF DEATH (A) PULMONARY Embolus DUE TO (B) _____ DUE TO (C) CARCINOMA @ BREAST | | INTERVAL BETWEEN ONSET AND DEATH |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 9-17-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA @ BREAST | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) yes | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that the (this hospital) attended the deceased from 9-16-65 19 to 9-21-65 19, that (I) we (we) last saw the deceased alive on 9-21-65 19 and that in (my) our (our) opinion death occurred on the date and hour and from the causes stated above. (I) We (We) (did) did not view the body after death. | | | | | |
| 23A. SIGNATURE Michael B. Flynn | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9-21-65 |
| 23C. PHYSICIAN'S NAME (Type) Michael B. Flynn | | | 23D. ADDRESS 1214 A WALKER AVE BALTIMORE | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9/25/65 | 24C. NAME OF CEMETERY or CREMATORY Landon Park | | 24D. LOCATION (City, town, or county) (State) Balto. 29. Md | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 23 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Witt & W. 4101 E. Monahan | |

The body of Howard Bailey was released to The Johns Hopkins Hospital by Dr. Brictnacker, Non-Med. FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------|--------------------------------------------------------------------------|----------------------------------------------------------------------|
| BIRTH NO. 65 9777 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9777 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Howard Bailey | | 2. DATE AND HOUR OF DEATH 9/21/65 9.00 P M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MA RYLAND 7-02 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) 2401 EAST EAGER STREET | | | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 7-26-28 | 9. AGE (In years lost birthday) 37 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore Md | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME VERNON BAILEY | | 14. MOTHER'S MAIDEN NAME RUBY JOHNSON | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Kous Bailey | ADDRESS Same | |
| 18. 710.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Scleroderma with pulmonary, due to cardiac and skin involvement (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/21/65 19 to 9/21 19 65, that (I) (we) last saw the deceased alive on 9/21 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (II) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Herman K. Gold | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-21-65 | |
| 23C. PHYSICIAN'S NAME (Type) Herman K. Gold | | M.D. 23D. ADDRESS Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9-25-65 | 24C. NAME OF CEMETERY or CREMATORY MT. CALVARY Cem. | | 24D. LOCATION (City, town, or county) (State) Brooklyn, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 23 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR E. Gray O. Wilson 1000 Blantyre Ave. | |



| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------|------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|-----------------------------------------------------|--|--|
| BIRTH NO. <u>65 9778</u> | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. <u>65 9778</u> | | | | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>DAVID GARDNER</u> | | | | | 2. DATE AND HOUR PRONOUNCED DEAD <u>September 23, 1965</u> <u>6:45 A</u> M. | | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Franklin Square Hospital</u> | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>129 N. Fulton Avenue</u> | | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>Negro</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Separated</u> | 8. DATE OF BIRTH <u>12/10/1917</u> | 9. AGE (In years last birthday) <u>47</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 13. FATHER'S NAME <u>William Gardner</u> | | | 14. MOTHER'S MAIDEN NAME <u>Nesta</u> | | | 17. INFORMANT <u>Lillian Tamm 131 N. Fulton Ave</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES WWII</u> | | | 16. SOCIAL SECURITY NO. | | ADDRESS | | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>443 X I</u> (A) <u>Hypertensive Cardiovascular Disease.</u> DUE TO (B) _____ DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH | | | | | ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <u>Fatty Liver.</u> | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u> | | | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>Charles S. Petty, M.D.</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | |
| DATE SIGNED <u>9/23/65</u> | | | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23B. DATE <u>9/23/65</u> | | 23C. NAME of CEMETERY or CREMATORY <u>Bethesda National</u> | | 23D. LOCATION (City, town, or county) (State) <u>Bethesda</u> | | | |
| 24A. DATE REC'D BY HEALTH DEPT. <u>SEP 23 1965</u> | | 24B. NAME OF REGISTRAR <u>Robert E. Farley</u> | | 24C. FUNERAL DIRECTOR <u>James Lee R. Hays</u> | | ADDRESS <u>638 N. Greenway</u> | | | |

WALLACE FORGEE

PAGE SEVENTEEN

Charles W. Wallace

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9779 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9779 | |
| NAME OF DECEASED (Type or Print) Beverly Myrtle Willits | | DATE AND HOUR OF DEATH September 22, 1965 8:50 P.M. | | | |
| PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION U.S. Public Health Service Hospital Baltimore, Maryland | | USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 2709 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1338 Winston Avenue | | | |
| 5. SEX Fem | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Mar | 8. DATE OF BIRTH Jan-7-1926 | 9. AGE (In years last birthday) 39 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY -- | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME William H. Jones | | 14. MOTHER'S MAIDEN NAME Alice Frickman | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 196-14-3511 | | 17. INFORMANT ADDRESS Records - USPHS Hospital, Baltimore, Md. | |
| 18. 204.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Intercranial hemorrhage DUE TO (B) Thrombocytopenia DUE TO (C) Acute myelogenous leukemia | | INTERVAL BETWEEN ONSET AND DEATH 1 - 2 hours 4 months | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that 10 (this hospital) attended the deceased from September 9 1965 to September 22 19 65 , that 11 (we) last saw the deceased alive on September 22 19 65 and that in 202 (our) opinion death occurred on the date and hour and from the causes stated above. 11 (We) (did) 202 view the body after death. | | | | | |
| 23A. SIGNATURE Donald J. Lawler M.D. | | | | 23B. DATE SIGNED September 22, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Donald J. Lawler, Surgeon | | 23D. ADDRESS USPHS Hospital, Baltimore, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Rem. Burial | | 24B. DATE 9/27/1965 | | 24C. NAME of CEMETERY or CREMATORY Paxtang | |
| 24D. LOCATION (City, town, or county) Harrisburg, Pa. | | 24E. STATE (State) Pa. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 23 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Henry J. Jenkins | |
| 25D. ADDRESS 4905 York Rd | | 25E. CITY, STATE, ZIP Baltimore, Md. 21212 | | | |

October 22, 1900

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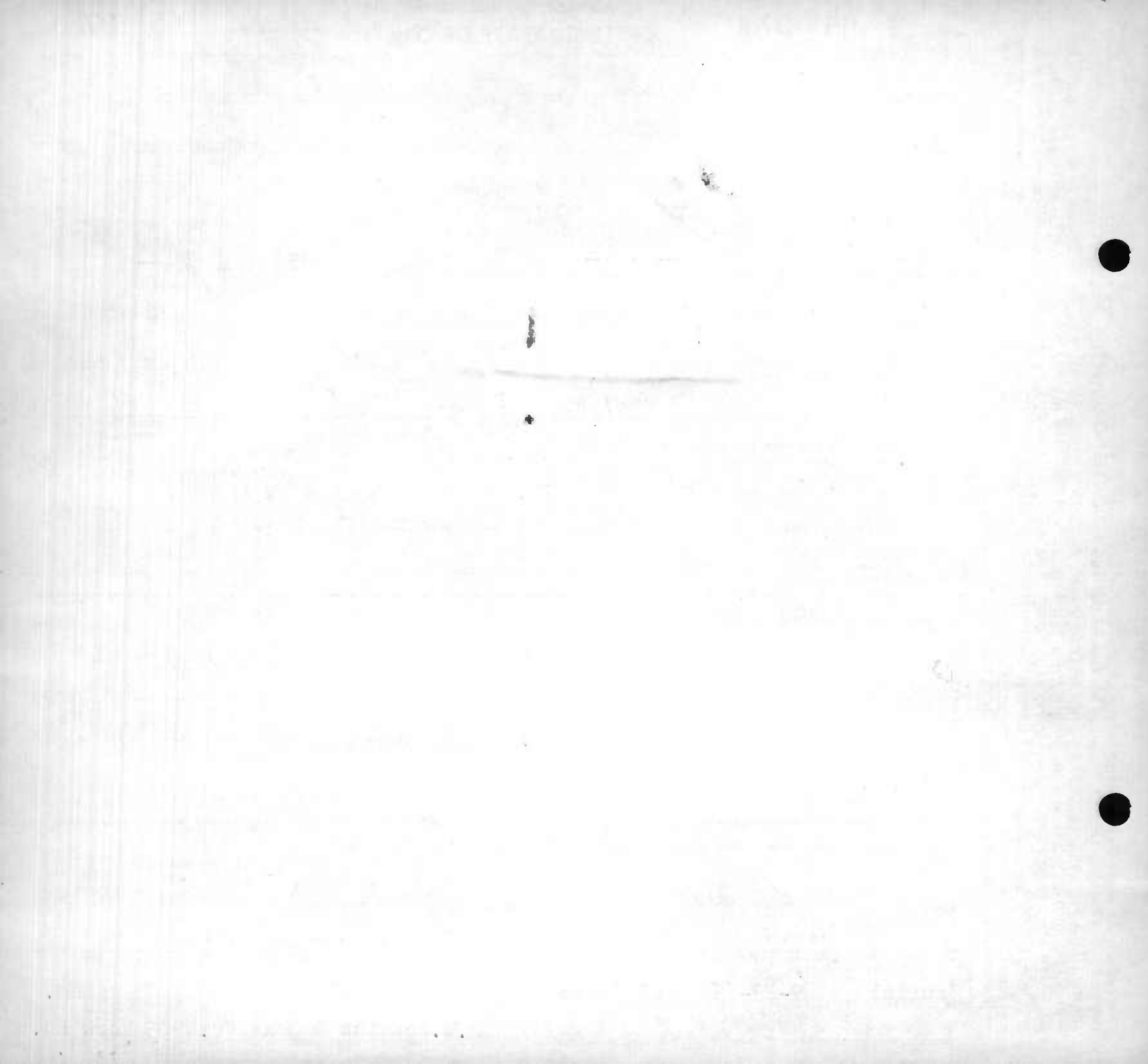
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9780 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9780 | |
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| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Carrie Elizabeth Cook</u> | | | | 2. DATE AND HOUR OF DEATH <u>9/22/65</u> <u>8:30</u> A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>27-02</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University Hospital</u> (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <u>2902 Montebello Terrace</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>(WIDOWED)</u> | | 8. DATE OF BIRTH <u>3/3/87</u> | 9. AGE (In years lost birthday) <u>78</u> | If Under 1 Yr. Months: Days: Hours: Min. <u>6</u> <u>14</u> <u>11</u> <u>11</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Henry Wagner</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Margaret Milles Wagner</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>219-01-3822B</u> | | 17. INFORMANT <u>George Hallmif</u> ADDRESS <u>4301 Flitwood Ave</u> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) <u>Metastatic carcinoma</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Phylloides and Intraductal carcinoma of Right breast</u> | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH <u>August 1964 to Sept. 22 '65</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <u>February 1965</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Guadied</u> | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>September 7</u> 19 <u>65</u> to <u>September 22</u> 19 <u>65</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>Sept 22</u> 19 <u>65</u> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>We</u>) (<u>did</u>) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Youngsik Moon</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>September 22 '65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>YOUNGSIK MOON</u> | | | | 23D. ADDRESS <u>827 Linden Ave. Baltimore, MD.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9-23-65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Baltimore</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 23 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md.</u> | | | |



65 9781

BALTIMORE CITY HEALTH DEPARTMENT

65 9781

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Thomas LEO HARRINGTON

2. DATE AND HOUR PRONOUNCED DEAD

9/20/65 14:15 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

5703 Sefton Ave.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5703 Sefton Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

single

8. DATE OF BIRTH

Oct. 16, 1895

9. AGE (in years
last birthday)

69

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Timothy Harrington

14. MOTHER'S MAIDEN NAME

Mary Hand

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown, (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. John E. Kaufman, 1518 Stonewood Road

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)Arteriosclerotic cardiovascular disease
(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT
WORKNOT WHILE
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/21/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/22/65

23C. NAME OF CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

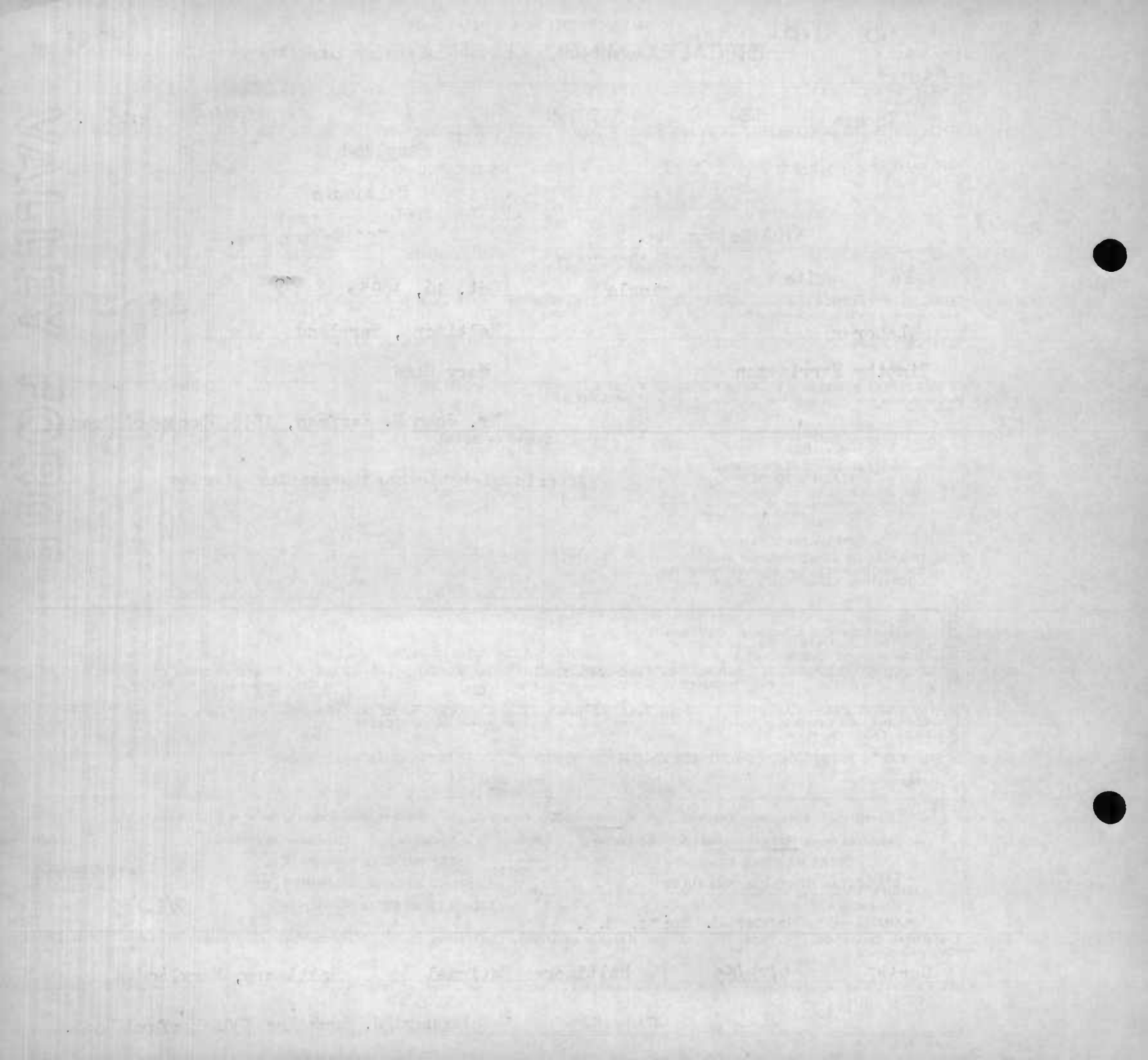
24C. FUNERAL DIRECTOR

ADDRESS

SEP 23 1965

Robert E. Farkas

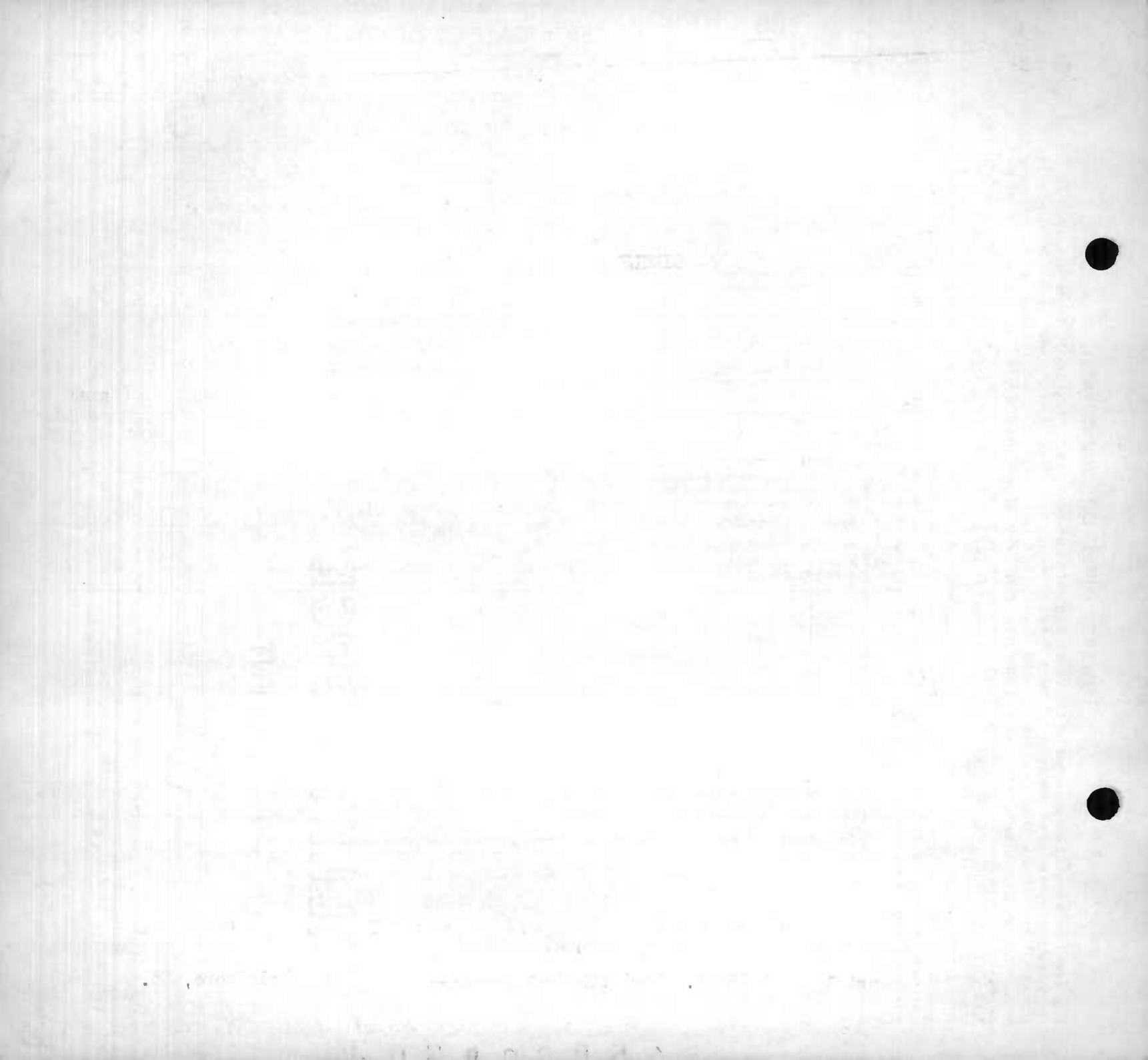
Leonard J. Ruck Inc 5305 Harford Road.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-----------------------------------|--------------------------------------------------------------------------------------------|
| 65 9782 | | CERTIFICATE OF DEATH | | 65 9782 | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR OF DEATH | | |
| ANNIE I. MORWOOD | | | SEPTEMBER 22, 1965 5:23 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | A. STATE B. COUNTY | | |
| NORTH CHARLES GENERAL HOSPITAL | | | MARYLAND | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | |
| | | | BALTIMORE | | |
| | | | D. STREET ADDRESS (If rural, give location) | | |
| | | | 5406 GERLAND AVE. | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| FEMALE | WHITE | SINGLE | FEB 9/1885 | 80 | HOUSEWIFE |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| | | | MARYLAND | | U. S. A. |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| WILLIAM MORWOOD | | | CATHERINE CASEY | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT | | ADDRESS |
| No | | | AGNES ETZEL (SISTER) | | (Same) |
| 18. CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | (A) Cerebrovascular Hemorrhage | | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | DUE TO | | |
| ANTECEDENT CAUSES | | | (B) Hypertensive Arteriosclerotic Cardid- | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | DUE TO Vascular Disease | | |
| | | | (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 18 1965 to Sept 22 1965, that (I) (we) last saw the deceased alive on Sept 22 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | 23B. DATE SIGNED | | |
| M. D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | Sept 22, 1965 | | |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS | | |
| DR. HINNO | | | 5002 Frankford ave | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) |
| Burial | | 9/25/65 | New Cathedral Cemetery | | Baltimore, Md. |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| SEP 23 1965 | | Robert E. Fickner | | Leisard. J. Rock/nc. 5305 Harford | |



1

65 9783

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 9783

BIRTH NO.

M.E. CASE NO.

D-120

1. NAME OF DECEASED (Type or Print) DONALD R. DAVIS

2. DATE AND HOUR PRONOUNCED DEAD September 22, 1965 10:30 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)

A. STATE FLORIDA

B. COUNTY K-18

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) HOLLYWOOD

D. STREET ADDRESS (If rural, give location) 7091 N.W. 25th Street

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) St. Joseph's Hospital

5. SEX Male

6. RACE White

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED

8. DATE OF BIRTH MARCH 6, 1934

9. AGE (In years last birthday) 31

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEEL WORKER

10B. KIND OF BUSINESS OR INDUSTRY BALTO. RIGGING CO.

11. BIRTHPLACE (State or foreign county) NEW JERSEY

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME RICHARD W. DAVIS

14. MOTHER'S MAIDEN NAME MARGARET RIGBY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS MRS. PATRICIA A. DAVIS 7091 N. West 25th St. Hollywood, Florida

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple Traumatic Injuries.

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 9/21/65

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Construction Site

21C. WHERE DID INJURY OCCUR? Frederick, Maryland 60-00

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 9 21 '65 A

21E. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? Struck by falling piece of concrete

22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 9/23/65

23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL

23B. DATE 9/28/65

23C. NAME OF CEMETERY or CREMATORY HOLLYWOOD MEMORIAL GARDENS

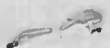
23D. LOCATION (City, town, or county) (State) HOLLYWOOD, FLORIDA

24A. DATE REC'D BY HEALTH DEPT. SEP 23 1965

24B. NAME OF REGISTRAR Robert E. Fahrenholz

24C. FUNERAL DIRECTOR ADDRESS LEONARD J. RUCK, INC., BALTO., MD. 21214

VS 151-REV. 1/1/65



Handwritten signature or initials, possibly "C. L. B." or similar, written in a cursive style.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|--------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------|--------------------------------|
| 65 9784 | | CERTIFICATE OF DEATH | | 65 9784 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | EDWARD L. GETTIER | | 9:45 PM 9/20/65 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| UNION MEMORIAL HOSP. | | MARYLAND | | BALTIMORE | |
| D. STREET ADDRESS (If rural, give location) | | E. CITY OR TOWN (If outside city limits, write RURAL and give township) | | F. STREET ADDRESS (If rural, give location) | |
| 1220 S. HANOVER ST. | | BALTIMORE | | BALTIMORE | |
| 6. SEX | 7. RACE | 8. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 9. DATE OF BIRTH | 10. AGE (In years lost birthday) | 11. If Under 1 Yr. Months Days |
| M | W | MARRIED | 1/28/25 | 40 | 40 |
| 12A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 12B. KIND OF BUSINESS OR INDUSTRY | | 13. BIRTHPLACE (State or foreign country) | |
| ASSEMBLYMAN | | FRANKLIN BALMAR CO. | | BALTIMORE | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. CITIZEN OF WHAT COUNTRY? | |
| THOMAS GETTIER | | LAURA WHEAT | | USA | |
| 17. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 18. SOCIAL SECURITY NO. | | 19. INFORMANT | |
| UNK. | | UNK. | | PATIENT | |
| 20. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | 21. CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | 22. INTERVAL BETWEEN ONSET AND DEATH | |
| INTERNAL HEMORRHAGE | | INTERNAL HEMORRHAGE | | 3 days | |
| ANTECEDENT CAUSES | | LYMPHO SARCOMA | | 4 months | |
| 23. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | 24. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 25. MEDICAL CERTIFICATION | |
| II | | 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 19/1/65 | | Bilat. ing. Hernia | | NO | |
| 26A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 26B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 26C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 26D. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 26E. INJURY OCCURRED | | 26F. HOW DID INJURY OCCUR? | |
| (APPROX.) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 26F. HOW DID INJURY OCCUR? | |
| 27. I certify that (this hospital) attended the deceased from (we) last saw the deceased alive on (We) (did) (did not) view the body after death. | | 28. DATE SIGNED | | 29. ADDRESS | |
| 8/30/65 | | 9/20/65 | | 9:45 PM 9/20/65 | |
| 30A. SIGNATURE | | 30B. DATE SIGNED | | 30C. ADDRESS | |
| Robert N. Whitlock | | 9/20/65 | | UNION MEMORIAL HOSPITAL | |
| 31A. BURIAL CREMATION, REMOVAL (Specify) | | 31B. DATE | | 31C. NAME of CEMETERY or CREMATORY | |
| Burial | | 9 25 65 | | Balto. U. S. National | |
| 31D. DATE REC'D BY HEALTH DEPT. | | 31E. NAME OF REGISTRAR | | 31F. FUNERAL DIRECTOR | |
| SEP 23 1965 | | Robert E. Fairbank | | J. Cully | |
| 32. VS 150-REV. 1/1/65 | | 33. ADDRESS | | 34. ADDRESS | |
| 130 E. 70th St. | | 130 E. 70th St. | | 130 E. 70th St. | |

THE UNIVERSITY OF CHICAGO

LIBRARY OF THE UNIVERSITY OF CHICAGO

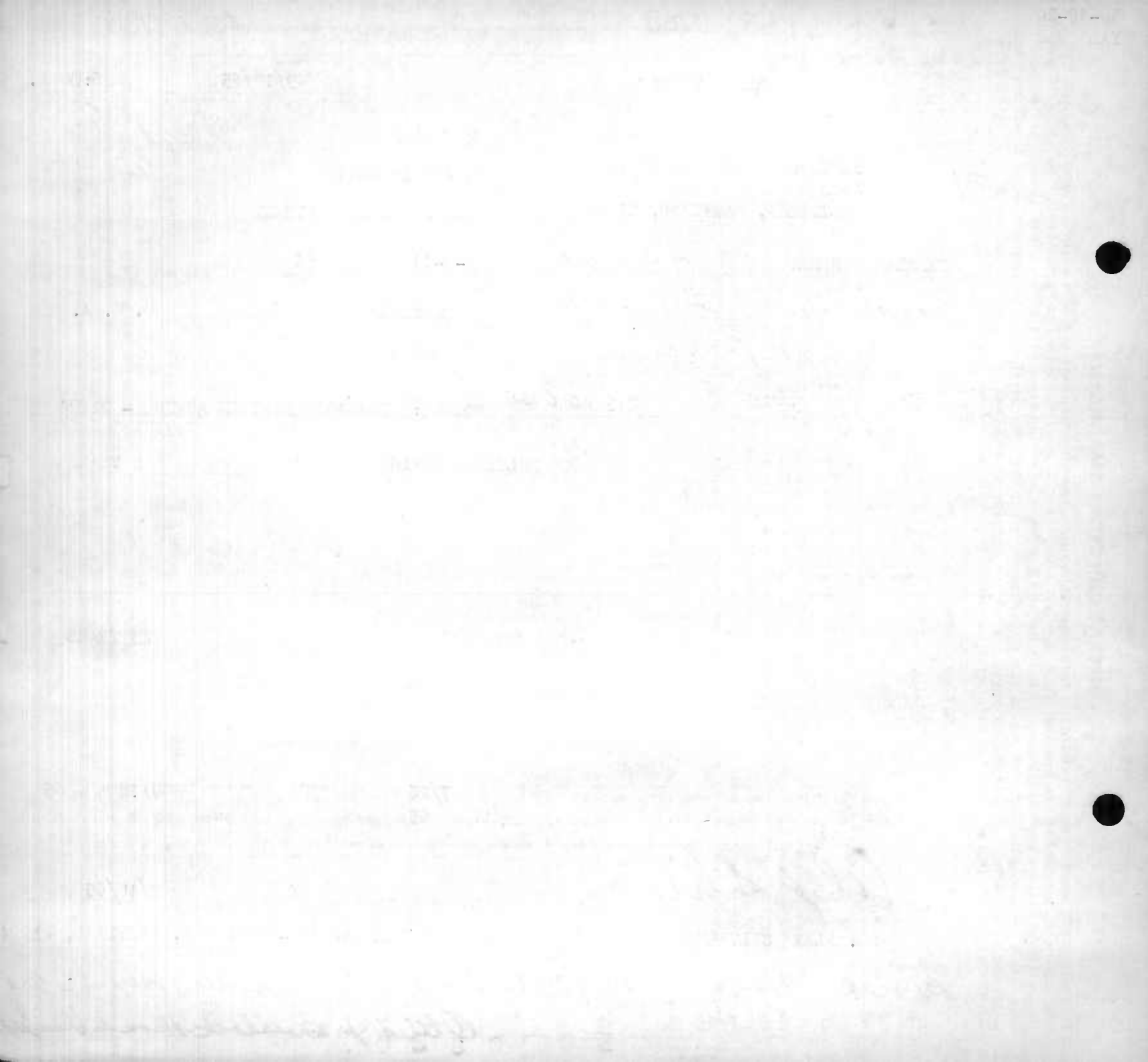
38-10-20

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|--|
| BIRTH NO. <u>W-514 65 9785</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. <u>65 9785</u> | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) PEARLINE WINFIELD | | | | 2. DATE AND HOUR OF DEATH 9/18/65 6:00 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BALTIMORE CITY HOSPITAL 4940 EASTERN AVENUE BALTIMORE, MARYLAND, 21224 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY HAYFORD C. CITY OR TOWN (If outside city limits, write RURAL and give township) HAVRE de GRACE D. STREET ADDRESS (If rural, give location) 312 WASHINGTON STREET | | | |
| 5. SEX FEMALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced | 8. DATE OF BIRTH 8-8-11 | 9. AGE (In years lost birthday) 54 | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Housewife | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME John B. Brown | | | 14. MOTHER'S MAIDEN NAME Adeline Taylor | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. 213-05-6765 | | | 17. INFORMANT ADDRESS RECORDS: BCM 4940 EASTERN AVENUE - 21224 | | | | |
| 18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) MULTIPLE MYELOMA DUE TO INTERVAL BETWEEN ONSET AND DEATH 5 YEARS | | | | | | | |
| II ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. HYPERTHYROIDISM DUE TO INTERVAL BETWEEN ONSET AND DEATH 23 YEARS | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/26 19 63 to 9/18 19 65 , that (I) (we) last saw the deceased alive on 9/17 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE DR. ALEX SILVERMAN | | | | 23B. DATE SIGNED 9/18/65 | | 23C. PHYSICIAN'S NAME (Type) DR. ALEX SILVERMAN | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/22/65 | | 24C. NAME of CEMETERY or CREMATORY Asbury Methodist Cem. | | 24D. LOCATION (City, town, or county) (State) Churchville, Hayford Co. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 23 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Othello J. Bullock, Havre de Grace, Md. | | | |



| 65 9786 | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 9786 | |
|--------------------------------------------------------------------|---------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|
| BIRTH NO. | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | Registered No. | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | |
| | | Thomas Reid short | | September 19, 1965 4:35 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE | |
| | | Maryland | | B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | | | |
| PROVIDENT HOSPITAL | | Baltimore | | 15-06 | |
| D. STREET ADDRESS (If rural, give location) | | 2048 Braddish Ave. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| Male | Negro | Married | Aug. 8, 1900 | 65 | Laborer |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | |
| Virginia | | | | Peter Reid | |
| 14. MOTHER'S MAIDEN NAME | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| Maggie Bivens | | | | 215-01-0864 | |
| 17. INFORMANT | | 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| Beatrice Reid | | 422.1 & 153.3 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Carcinoma of sigmoid colon | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | No | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | |
| 22. | | I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 9-20-65 | |
| Russell S. Fisher, M.D. | | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME of CEMETERY or CREMATORY | |
| Burial | | 9/23/65 | | Arbutus Mem. Ch. Baltimore Md. | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR | |
| SEP 23 1965 | | Robert E. Fairbank | | Arlington S. Phillips 1727 N. Mount St. | |

[Faint, illegible handwriting, possibly bleed-through from the reverse side of the page.]

[Faint, illegible handwriting at the bottom of the page, possibly bleed-through.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------|--|
| BIRTH NO. 65 9787 | | | | | CERTIFICATE OF DEATH | | | | |
| M.E. CASE NO. | | | | | Registered No. 65 9787 | | | | |
| 1. NAME OF DECEASED (Type or Print) DORIS DAVIS | | | | | 2. DATE AND HOUR OF DEATH 9-17-65 8.40 P.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 8-05 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1644 EAST 25TH STREET | | | | |
| 5. SEX FEMALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | | 8. DATE OF BIRTH 7-15-23 | 9. AGE (In years last birthday) 42 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore Md. | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME THOMAS LEWIS | | | | | 14. MOTHER'S MAIDEN NAME ETHEL BROOKS | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT George Davis | | | ADDRESS 1644 E. 25th St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 171X I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertensive Cardiovascular disease | | | | | CAUSE OF DEATH (A) Hypovolemia 2° to DUE TO (B) Sepsis and Septic shock DUE TO (C) Carcinoma of Colon - Persistent After radiotherapy | | INTERVAL BETWEEN ONSET AND DEATH 24 hrs 48 hrs Known 2 weeks | | |
| 19A. DATE OF OPERATION 1/9/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of Colon | | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3 19 65 to 9/17 19 65, that (I) (we) last saw the deceased alive on 9/17 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. Pronounced 8:40 PM. | | | | | | | | | |
| 23A. SIGNATURE J. Bruce Iuppa | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED 9/22/65 | |
| 23C. PHYSICIAN'S NAME (Type) J. BRUCE IUPPA | | | | | 23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/22/65 | | 24C. NAME OF CEMETERY or CREMATORY St. Rest | | | 24D. LOCATION (City, town, or county) (State) Harmon Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 23 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | | 25C. FUNERAL DIRECTOR Arlington S. Phillips 1727 N. Monmouth St. | | | | |

JOHN HOPKINS

1994

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9788 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9788 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MEADS, ALVINA | | 2. DATE AND HOUR OF DEATH 9-22-65 4:50A M. | |
| 3. PLACE OF DEATH FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE ZONE #8 | |
| 5. SEX FEMALE | | 6. RACE WHITE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | | 12. CITIZEN OF WHAT COUNTRY? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no none | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ST. AGNES RECORDS-CATON & WILKENS AVES | |
| 18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cerebral hemorrhage | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH days | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (we) (this hospital) attended the deceased from SEPTEMBER 20 1965 to SEPTEMBER 22 1965, that (we) last saw the deceased alive on SEPTEMBER 22 1965 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Pedro P. Purcell, MD | | M.D. Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-22-65 | |
| 23C. PHYSICIAN'S NAME (Type) PEDRO P. PURCELL, MD | | 23D. ADDRESS St. Agnes Hosp. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE SEP 24 1965 | | 24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | |
| 24D. LOCATION Woodlawn, Md. | | 24E. CITY, TOWN, OR COUNTY Baltimore | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 24 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR Frank H. Howell | |
| 25D. ADDRESS | | 25E. ADDRESS | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9789 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9789 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH M. | |
| | | Elizabeth Jane Benner | | Sept. 23, 1965 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital | | | A. STATE Md. | | |
| (If not in hospital or institution, give street address or location) | | | B. COUNTY | | |
| 5. SEX Female | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 15, Md. | | |
| 6. RACE White | | | D. STREET ADDRESS (If rural, give location) 4033 Lewiston Ave. | | |
| 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed | | | 8. DATE OF BIRTH March 8, 1867 | | 9. AGE (In years lost birthday) 98 yrs. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY own home | | 11. BIRTHPLACE (State or foreign country) Carroll Co., Md. | |
| 13. FATHER'S NAME William Roberts | | | 14. MOTHER'S MAIDEN NAME Rebecca Kidd | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) None | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Eva Mary Gilbert, 4033 Lewiston Ave., Baltimore 15, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I CAUSE OF DEATH Acute Coronary Thrombosis (A) DUE TO Arterio-sclerotic heart about 10 years disease (B) DUE TO Generalized arterio-sclerotic (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH About 10 years | | | 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from 1949 to Sept. 23, 1965, that (I) (we) lost saw the deceased alive on Sept. 13, 1965, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Julius C. Gluck | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Julius C. Gluck | | | | 23D. ADDRESS 3356 Reisterstown Rd. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Sept. 27, 1965 | | 24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Pikesville 8, Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 24 1965 | | 25B. NAME OF REGISTRAR Frank H. Newell | |
| 25C. FUNERAL DIRECTOR Frank H. Newell | | 25D. ADDRESS Pikesville 8, Md. | | 25E. SIGNATURE Frank H. Newell | |

Blue Canyon, Texas

Agave - Schott's Plant
Ficus
Rumex crispus

10/10/10

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10/10/10

Agave Schottii

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
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| 65 9790 | | | | | Registered No. 65 9790 | | | | |
| BIRTH NO. | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) ALASCIO, MARY (ALASCIA) | | | | | 2. DATE AND HOUR OF DEATH 9/22/65 4:15 P.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY USA | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME + HOSPITAL BALT. MD. | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | | |
| D. STREET ADDRESS (If rural, give location) 517 DENNISON ST | | | | | | | | | |
| 5. SEX F | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 6-4-90 | 9. AGE (in years lost birthday) 75 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) ITALY | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME VINCENT BARRAKO | | | 14. MOTHER'S MAIDEN NAME THERESA CURRERI | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. NONE |
| 17. INFORMANT ADDRESS JOSEPH V. ALASCIO 179 E. OSTEAD ST | | | 18. CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 260X + 151X | | | (A) Coronary-vascular accident, thrombotic | | | 2 mrs. | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) Arteriosclerotic cardiovascular system | | | | | | |
| | | | (C) diabetic disease | | | years | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION July 15, 1965 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of the stomach | | 20A. AUTOPSY? (Yes or No) no | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7-7-65 to 9-22-65 , that (I) (we) last saw the deceased alive on 9-22-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE José S. Maisos M.D. | | | | | 23B. DATE SIGNED 9-22-65 | | | 23C. PHYSICIAN'S NAME (Type) José S. Maisos M.D. | |
| 23D. ADDRESS Church Home + Hospital | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-25-1965 | | 24C. NAME of CEMETERY or CREMATORY NEW CATHEDRAL | | 24D. LOCATION (City, town, or county) (State) BALTIMORE MD. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 24 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR WEBER FUNERAL HOME | | 25D. ADDRESS 5317 DENNISON AVE | | | |

Bar Mr. J. J. J.

White House

Washington

President

Mr.

Mr.

Bar Mr. J. J. J.

White House

Washington

President

Mr.

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Mr.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9791 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|-------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| BIRTH NO. 65 9791 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Kowalewski, Stella</i> | | 2. DATE AND HOUR OF DEATH <i>9/21/65 8²⁵ A.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE <i>MD</i> B. COUNTY <i>FO3</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>No. 1 Charles Sen. Hospital</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balt - 24 - 2nd -</i> | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| 5. SEX <i>Female</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i> | 8. DATE OF BIRTH <i>11-15-93</i> | 9. AGE (In years last birthday) <i>72</i> | <div style="display: flex; justify-content: space-between;"> <div>If Under 1 Yr. Months: Days: Hours: Min.</div> <div>If Under 24 Hrs. Hours: Min.</div> </div> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Germany</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>Kulski ANTONI</i> | | 14. MOTHER'S MAIDEN NAME <i>Nowak FRANCES</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>213-14-2240</i> | | 17. INFORMANT ADDRESS <i>Son - Walter -</i> | |
| 18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <i>MYOCARDIAL INFARCTION</i> DUE TO (B) <i>ARTERIOSCLEROTIC CVS</i> DUE TO (C) <i>ARTERIOSCLEROSIS</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>Onset - 9/10/65</i> <i>Death 9/21/65</i> <i>at 8²⁵ AM</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (H) (this hospital) attended the deceased from <i>9/10/65</i> 19 to <i>9/21/65</i> 19, that (H) (we) last saw the deceased alive on <i>9/21/65</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <i>[Signature]</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>9/21/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>RAYMOND RAYGLE</i> | | 23D. ADDRESS <i>2938 - SAINT PAUL ST.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | 24B. DATE <i>9-25-65</i> | 24C. NAME OF CEMETERY or CREMATORY <i>ST. STANISLAUS Cem</i> | | 24D. LOCATION (City, town, or county) (State) <i>BALTIMORE MD</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 24 1965</i> | 25B. NAME OF REGISTRAR <i>[Signature]</i> | 25C. FUNERAL DIRECTOR <i>JOHN M. WEBER & SONS INC</i> | | ADDRESS <i>401 S. CHESTER ST.</i> | |

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65 9792

BALTIMORE CITY HEALTH DEPARTMENT

65 9792

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO.

M.E. CASE NO.

| | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print) WILLIE ROBINSON | | 2. DATE AND HOUR PRONOUNCED DEAD September 17, 1965 11:58 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 303 Pressman St. PRESSMAN | |
| 5. SEX male | 6. RACE negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 8/4/19 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY Garden | 11. BIRTHPLACE (State or foreign country) Race City Ga. |
| 13. FATHER'S NAME Gus Robinson | | 14. MOTHER'S MAIDEN NAME Mary | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W 2 | | 16. SOCIAL SECURITY NO. 266-10-9336 | |
| 17. INFORMANT Mrs Bertha Lipscomb | | ADDRESS 2147 Chelsea Terrace | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Lobar pneumonia INTERVAL BETWEEN ONSET AND DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Fatty metamorphosis of liver | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Yes | |
| 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | |
| 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Rudiger Breitenecker, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Rudiger Breitenecker, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED Sept. 17, 1965 | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 9/23/65 | |
| 23C. NAME OF CEMETERY or CREMATORY National Cemetry | | 23D. LOCATION (City, town, or county) (State) Baltimore Md | |
| 24A. DATE REC'D BY HEALTH DEPT. SEP 24 1965 | | 24B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 24C. FUNERAL DIRECTOR Adolphus Halstead | | ADDRESS 1206 W North Ave | |

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65 9793

BALTIMORE CITY HEALTH DEPARTMENT

65 9793

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

| | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|
| BIRTH NO. | | M.E. CASE NO. | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR PRONOUNCED DEAD | |
| JAMES LIVELY (H) | | September 22, 1965 2:25 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | A. STATE Maryland B. COUNTY | |
| Provident Hospital | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 17-01 D. STREET ADDRESS (If rural, give location) 537 Moore St. | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH |
| male | negro | ? | 11/1/94 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) |
| Unemployed | | | 70 |
| 13. FATHER'S NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| ? | | U S A | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
| | | | MRs Queenie Ward 539 Moore St |
| 18. CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH |
| I 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | (A) Arteriosclerotic cardiovascular disease DUE TO (B) DUE TO (C) DUE TO |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) |
| 0 | | | No |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) | | DATE SIGNED | |
| Rudiger Breitenecker, M.D. | | Sept. 22, 1965 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | 23C. NAME OF CEMETERY or CREMATORY |
| Burial | | 9/27/65 | National Cemetry |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | 23D. LOCATION (City, town, or county) (State) |
| SEP 24 1965 | | Robert E. Taylor | Baltimore Md |
| | | 24C. FUNERAL DIRECTOR | 24D. ADDRESS |
| | | Adolphus Halstead | 1206 W North Ave |

WALLLEY FORTICE

PACIFIC

65 9794

BALTIMORE CITY HEALTH DEPARTMENT

65 9794

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HENRY August MUELLER

2. DATE AND HOUR PRONOUNCED DEAD

September 23, 1965 3:30 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

712 N. Kenwood Avenue

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

WIDOWED

8. DATE OF BIRTH

10-31-1902

9. AGE (In years
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

SHIPPING CLERK

10B. KIND OF BUSINESS OR INDUSTRY

CLOTHING IND

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

HENRY A. MUELLER

14. MOTHER'S MAIDEN NAME

EMMA M. HOFMEISTER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Marie E. Mueller - 712 N. Kenwood Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) Hypertensive Heart Disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
9/23/6523A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

9-27-65

23C. NAME of CEMETERY or CREMATORY

LORRAINE PK. CEM.

23D. LOCATION

(City, town, or county)

(State)

BALTO., MD.

24A. DATE REC'D BY HEALTH DEPT.

SEP 24 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Hester Miller, 2334 Jefferson St.

ADDRESS

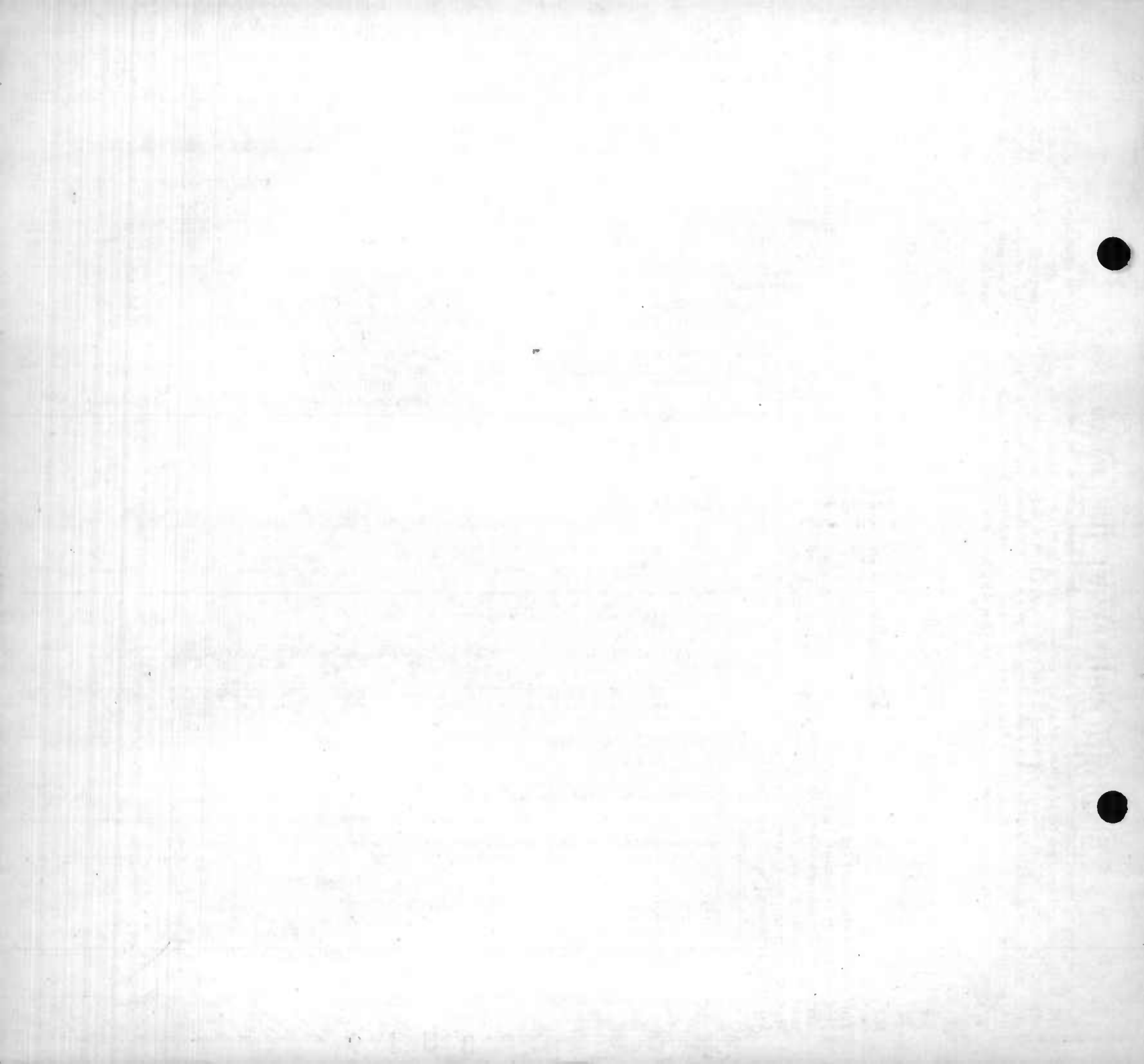
WALLACE PONDGE

PROFICIENT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

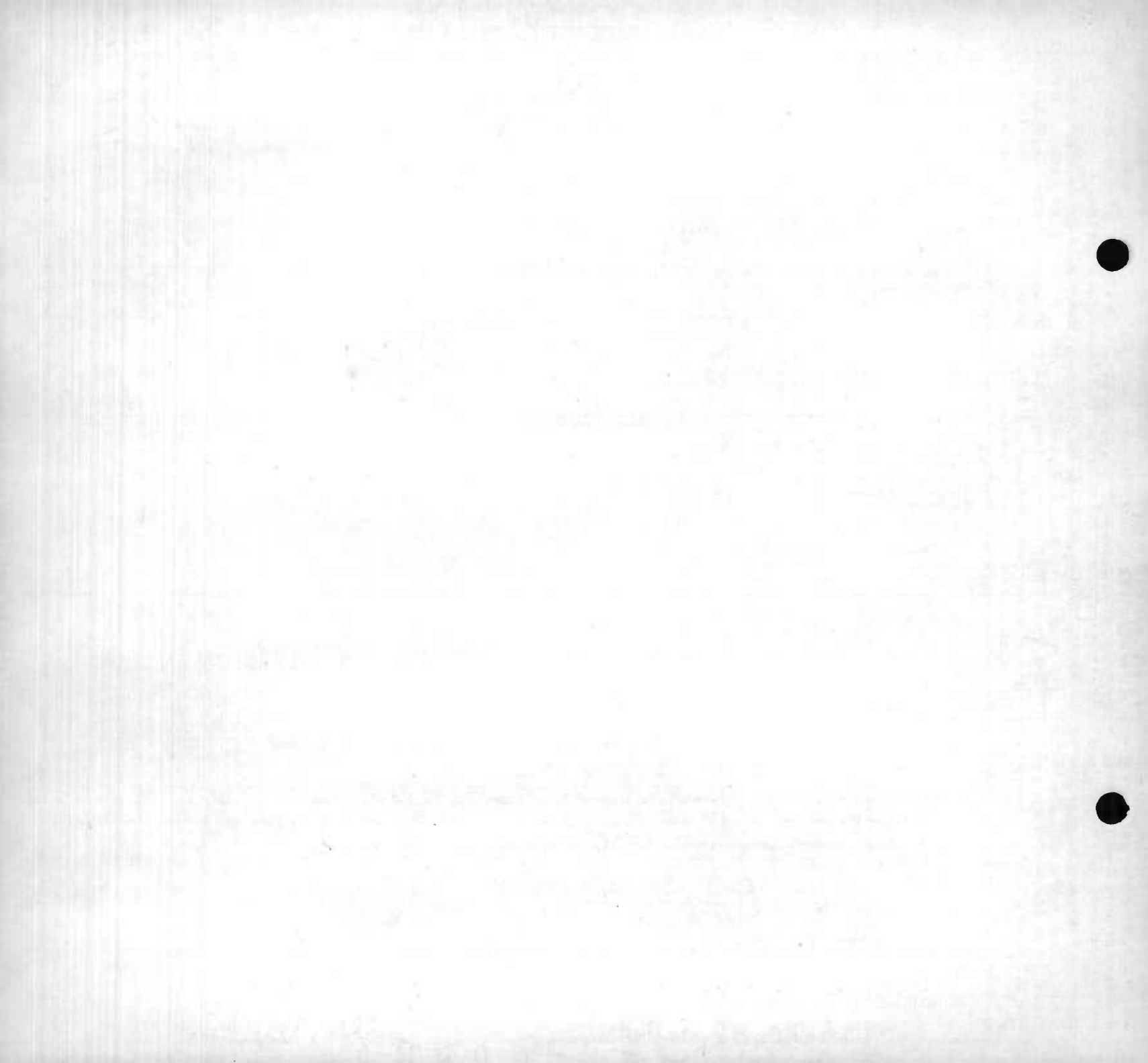
| | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------|--|
| BIRTH NO. 65 9795 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9795 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | 1. NAME OF DECEASED (Type or Print) Olive Clayton | |
| 2. DATE AND HOUR OF DEATH | | Sept 21, 1965 | | 5:20 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | A. STATE MARYLAND | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | B. COUNTY 26-34 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| PARK HILL CONVALESCENT HOME | | SALTMORE | | D. STREET ADDRESS (If rural, give location) | |
| 1009 Rodway Way | | 10. SEX F | | 11. RACE W | |
| 12. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 13. DATE OF BIRTH | | 14. AGE (In years lost birthday) | |
| WIDOWED | | 1-2-1877 | | 88 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| HOUSEWIFE | | HOME | | WEST VIRGINIA | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| HENRY KEPLINGER | | SARAH BEACH | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | | | Mr. Woodrow Clayton - 1009 Rodway Way | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) Cerebrovascular art. Sclerosis | | more than 2 yrs. | |
| ANTECEDENT CAUSES | | (B) Generalized Art Sclerosis | | yrs. | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/17 1961 to 9/21 1965, that (I) (we) last saw the deceased alive on 9/20 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| Louise B. Blum | | | | 9/21/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Louise B. Blum M.D. | | 3205 W. Rogers Ave Balto Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| BURIAL | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| SEP 24 1965 | | Robert E. Fairbank | | Barth Miller 2334-32 Jefferson St | |



Released to UH by Medical Examiner B.L. Johnson, M.D.
FUNERAL DIRECTOR: IMPORTANT

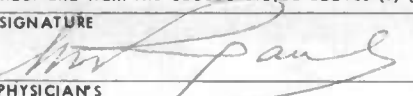
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|---------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------------|---------------------------------------------------|
| BIRTH NO. 651285765 9796 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9796 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) SHANNON LEE BONINE | | 2. DATE AND HOUR OF DEATH 9-21-65 1345 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL | | A. STATE MD. B. COUNTY 22-02 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | D. STREET ADDRESS (If rural, give location) 658 WASHINGTON BLVD | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED | 8. DATE OF BIRTH 5-23-65 | 9. AGE (In years lost birthday) 4 mos | 10. If Under 1 Yr. Months: Days: Hours: Min. 3/21 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant | | 10B. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 13. FATHER'S NAME Hobert Bonine | | 14. MOTHER'S MAIDEN NAME Grace McCoy | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. - | | 17. INFORMANT Chart | |
| | | | | ADDRESS UNIV Hosp | |
| 18. 754.5 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES | | (A) Congestive Heart failure DUE TO | | 3 mos | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Congenital heart lesion DUE TO | | life | |
| | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | None | | | |
| 19A. DATE OF OPERATION 2 None | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 21 19 65 to Sept 21 19 65, that (I) (we) last saw the deceased alive on Sept 21 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Barbara L. Johnson, M.D. | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 21 Sept 65 | |
| 23C. PHYSICIAN'S NAME (Type) Barbara L. Johnson | | 23D. ADDRESS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-24-65 | | 24C. NAME OF CEMETERY or CREMATORY BALTIMORE Cem. | |
| | | | | 24D. LOCATION (City, town, or county) (State) BALTO. MD | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 24 1965 | | 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR Stanley Miller | |
| | | | | ADDRESS | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 65 9797 | Registered No. 65 9797 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------|
| BIRTH NO. | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) Rosie Brim | | | 2. DATE AND HOUR OF DEATH 9/22/65 11:15 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 13-03 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital Inc | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) 2257 N. Fulton Avenue | | |
| 5. SEX F | 6. RACE C | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Yes (married) | B. DATE OF BIRTH 1-15-1922 | 9. AGE (In years lost birthday) 43 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME unknown | | | 14. MOTHER'S MAIDEN NAME Berdie Denal | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 214-12-0067 | 17. INFORMANT ADDRESS Ransom K. Brim 2257 N. Fulton Ave | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CONGESTIVE HEART FAILURE | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes. | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from September 22, 1965 to September 22, 1965 , that (I) (we) last saw the deceased alive on September 22, 1965 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE  23C. PHYSICIAN'S NAME (Type) Marie Rigaud | | | | 23B. DATE SIGNED September 23, 1965 | |
| | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | |
| | | 23D. ADDRESS 1514 Division Street | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-27-65 | | 24C. NAME of CEMETERY or CREMATORY Mt. Auburn | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 24 1965 | | 25B. NAME OF REGISTRAR Robert E. Farkner | | 25C. FUNERAL DIRECTOR 1735 Marshall W. Jones, Jr. Harford Ave. | |



1
M. 260

65 9798

BALTIMORE CITY HEALTH DEPARTMENT

65 9798

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ROBERT MCCRAW (Robert E. McCraw)

2. DATE AND HOUR PRONOUNCED DEAD

September 22, 1965 3:50 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Baltimore City Jail

4. USUAL RESIDENCE (Where deceased lived. If in institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6214 Copore Way #21224

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

November 15, 1926

9. AGE (In years
last birthday)

38

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

Laborer

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Luther E. McCraw

14. MOTHER'S MAIDEN NAME

Lelia Beckett

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W.W. 11

16. SOCIAL
SECURITY NO.

220-14-9279

17. INFORMANT

Annette McCraw

ADDRESS

6214 Copore Way #24

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A) Arteriosclerotic cardiovascular disease
DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN
ONSET AND DEATHII
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED
September 22, 196523A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-24-65

23C. NAME OF CEMETERY or CREMATORY

Baltimore National Cem.

23D. LOCATION

(City, town, or county)

(State)

5501 Frederick Ave, Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 24 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Charles A. Zeiler 901 S. Conkling St. #24

ADDRESS

VALLEY FOLIO

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 65 9799 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9799 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) HARRY GARLAND REYNOLDS | | 2. DATE AND HOUR OF DEATH Sept. 22, 1965 | | 4:15 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital Wyman Pk. Drive & 31st Street | | A. STATE Va. B. COUNTY V-13 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Winchester D. STREET ADDRESS (If rural, give location) 553 N. Loudon St. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH 8/2/26 | 9. AGE (In years lost birthday) 39 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AB | | 10B. KIND OF BUSINESS OR INDUSTRY Seafarer | | 11. BIRTHPLACE (State or foreign country) Va. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Harry Branson Reynolds | | 14. MOTHER'S MAIDEN NAME Jessie Farmer | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None | | 16. SOCIAL SECURITY NO. 227-22-1177 | | 17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO Metastatic Malignancy (B) DUE TO Renal Cell Carcinoma (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 5 Months 5 Months | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from June 18 19 65 to Sept. 22 19 65, that (I) (we) last saw the deceased alive on Sept. 22 4:15 PM 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Raymond D. Baker | | 23B. DATE SIGNED 9/22/65 | | 23C. PHYSICIAN'S NAME (Type) RAYMOND D. BAKER | |
| 23D. ADDRESS US Public Health Service Hospital, Balto, Md. | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-25-65 | |
| 24C. NAME OF CEMETERY or CREMATORY Gravel Springs | | 24D. LOCATION Frederick Co. Virginia | | 24E. DATE REC'D BY HEALTH DEPT. SEP 24 1965 | |
| 24F. NAME OF REGISTRAR Robert E. Farber, M.D. | | 24G. FUNERAL DIRECTOR F.C. Higginbotham | | 24H. ADDRESS Ellicott City Md. | |
| For Jones Funeral Home, Winchester, Va. | | | | | |

Michael J. McGowan
Greenville, S.C.

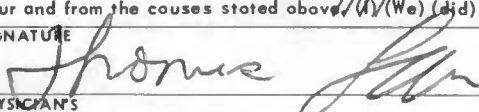
Raymond D. Vire
Greenville, S.C.

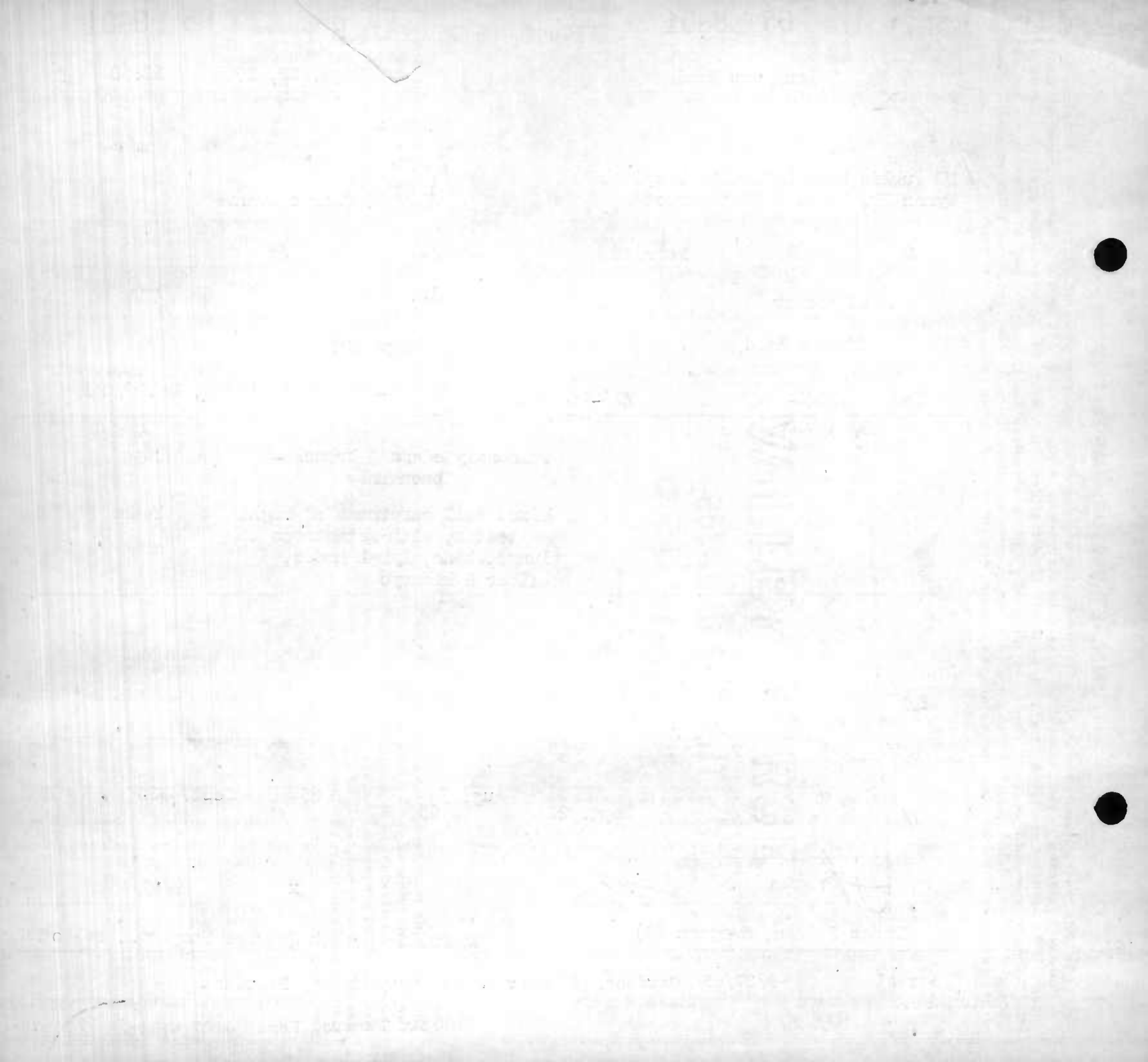
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------|--------------------------|---------------------------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. | | 65 9800 | | 65 9800 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| | | William E. Allen | | 9/21/65 5 ⁰⁰ P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | |
| Johns Hopkins Hospital | | | | South Carolina V-37 | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| | | | | Latta | |
| | | | | D. STREET ADDRESS (If rural, give location) | |
| | | | | Main St. | |
| 5. SEX | 6. RACE | 7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| M | W | | 4/10/17 | 48 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| OWNED Restaurant | | ← | | South Carolina | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Amandus (Unknown) | | | Mary (unknown) | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS |
| No | | | Unknown | | Patient's History |
| 18. 422.1 & 260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | |
| ANTECEDENT CAUSES | | | | (A) DUE TO | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | Arteriosclerotic cardio-vascular disease. | |
| II | | | | (B) DUE TO | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | (C) DUE TO | |
| Diabetes mellitus | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/10 19 65 to 9/21 19 65, that (I) (we) last saw the deceased alive on 9/21 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Jeffrey P. Aaronson M.D. | | | | 9/21/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| JEFFREY P. AARONSON M.D. | | | | Baltimore City Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| Removal | | 9/22/65 | | Removal by Hearse | |
| | | | | Latta, South Carolina | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| SEP 24 1965 | | Robert E. Fairbank | | Howard H. Hubbard, 4107 Wilkens Ave. | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

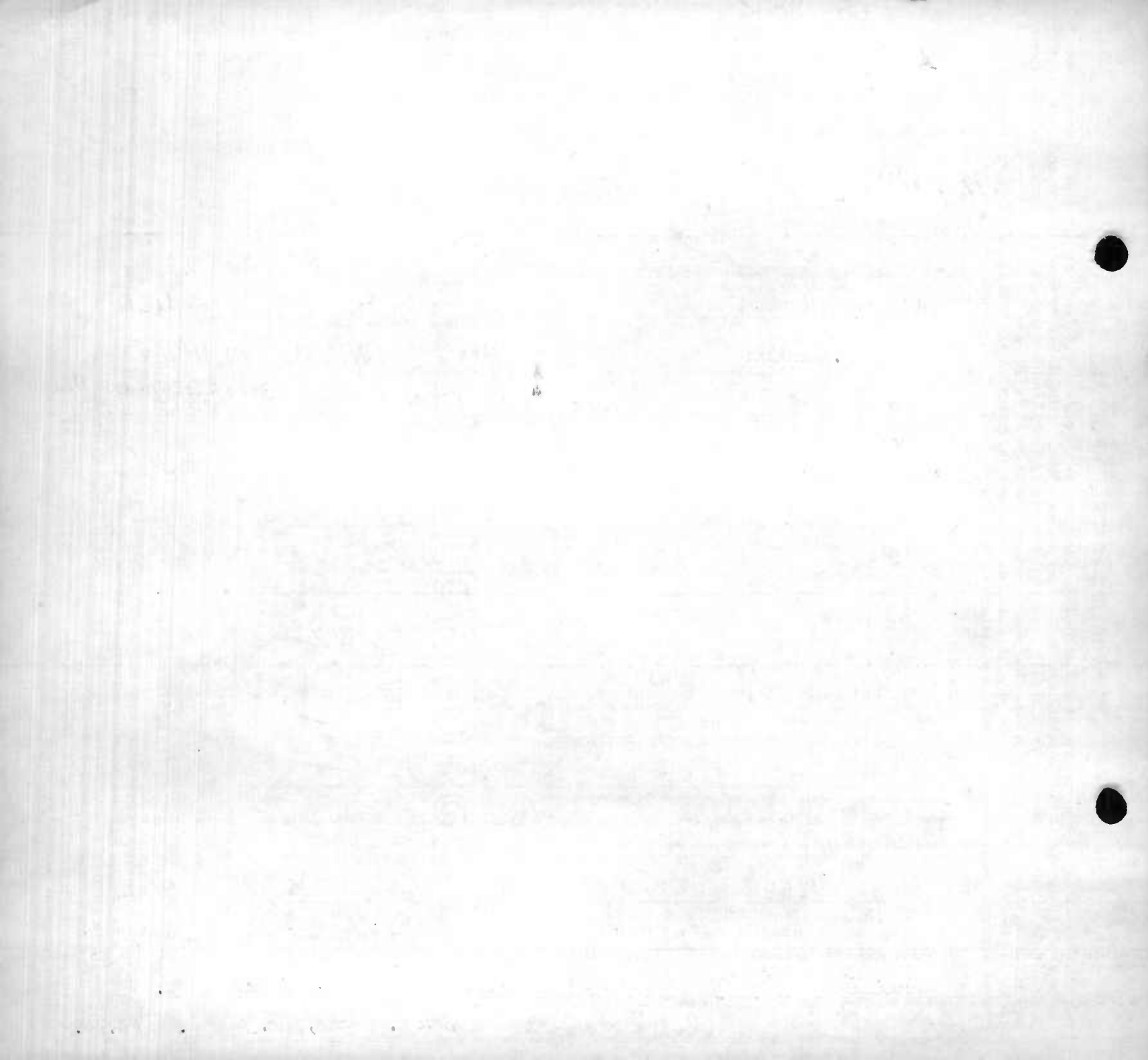
| | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|-----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------------------------|
| BIRTH NO. 65 9801 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9801 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Laneyver Reed | | Sept. 22, 1965 12:50 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | Florida | | |
| US Public Health Service Hospital Wyman Pk. Drive & 31st Street | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Tampa | | |
| | | | D. STREET ADDRESS (If rural, give location) 4307 S. Clarke Avenue | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 11/2/19 | 9. AGE (In years lost birthday) 45 | If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat packer | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Ala. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 13. FATHER'S NAME Thomas Reed | | | 14. MOTHER'S MAIDEN NAME Mary Odom | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1942-1943 | | 16. SOCIAL SECURITY NO. 416-16-3978 | | 17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md. | |
| 18. CAUSE OF DEATH | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | Pulmonary edema & broncho-pneumonia (A) DUE TO Mixed cell carcinoma of right testis, with metastases to lungs, bone, lymph nodes, liver & kidneys (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH Days Years |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Aug. 3, 1965 to Sept. 22, 1965, that (I) (we) last saw the deceased alive on Sept. 22, 1965 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE  Thomas J. Lau, Surgeon (R) | | | | 23B. DATE SIGNED 9/23/65 | |
| 23C. PHYSICIAN'S NAME (Type) Thomas J. Lau, Surgeon (R) | | 23D. ADDRESS US Public Health Service Hospital, Balto, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/27/65 | | 24C. NAME of CEMETERY or CREMATORY Gardens of Memories Cemetery Tampa, Florida | |
| 24D. LOCATION (City, town, or county) (State) Tampa, Florida | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 24 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Hubbard Funeral Home 4107 Wilkens Ave. 21229 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------|---------------------------------------|
| 9802 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9802 | |
| BIRTH NO. 111-976 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. 111-976 | | 1. NAME OF DECEASED (Type or Print) MRS GRACE GILL | | 2. DATE AND HOUR OF DEATH 9/22/65 4 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 7 WOMENS HOSPITAL JOHN ST. BALT. MD. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND. 9-03 B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALT. D. STREET ADDRESS (If rural, give location) 3607 GREENMOUNT AVE | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED X WIDOWED, DIVORCED (specify) Widow | | 8. DATE OF BIRTH 8/26/1874 | 9. AGE (In years lost birthday) 91 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME James M. Hampton | | 14. MOTHER'S MAIDEN NAME ANNIE PLUMBER HAMPTON | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT SON ADDRESS 3607 GREENMOUNT AVE BALT MD. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) pneumonia | | CAUSE OF DEATH (A) DUE TO pulmonary edema (B) DUE TO pneumonia (C) DUE TO pyelonephritis | | INTERVAL BETWEEN ONSET AND DEATH 30' 5 days 3 weeks | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ileus -> nephrectomy | | | |
| 19A. DATE OF OPERATION 1 9/7/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ileus | | 20A. AUTOPSY? (Yes or No) no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) no | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) — | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) — | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? — | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/5 1965 to 9/22 1965, that (I) (we) last saw the deceased alive on 9/22 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Dr. L. Wurmser | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/22 | |
| 23C. PHYSICIAN'S NAME (Type) Leon Wurmser | | 23D. ADDRESS 4 Edgecliff Road, Towson | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/25/65 | | 24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery | |
| 24D. LOCATION Baltimore Md. | | 24E. STATE Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 24 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Balto. St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

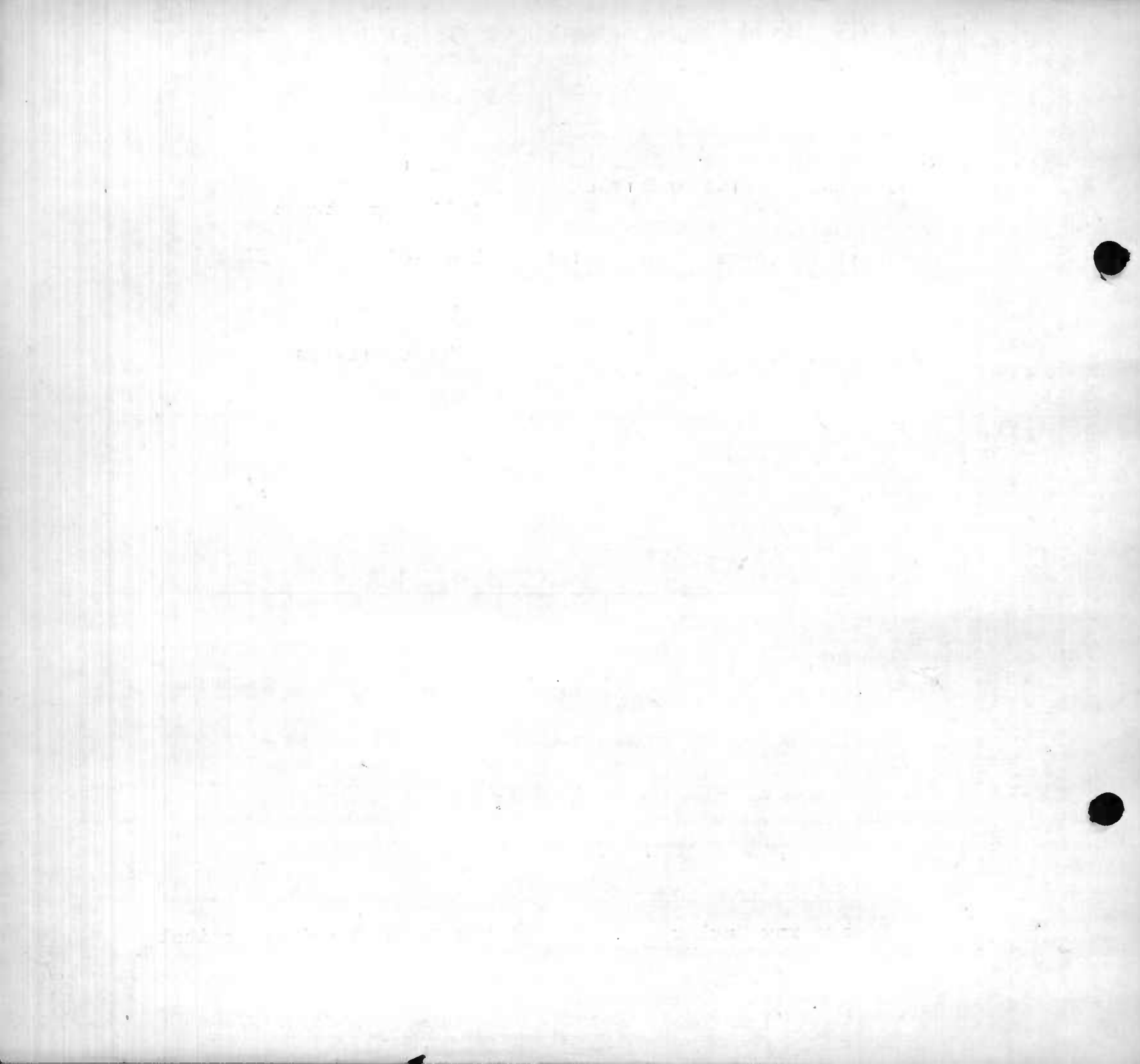
| | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|----------------------------------------------------------------------------------------|------------------------------------------|
| BIRTH NO. 65 9803 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9803 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Lucy Pointer, Kennedy</u> | | 2. DATE AND HOUR OF DEATH <u>9/22/65</u> <u>12 45 A</u> M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY HOSPITAL</u> | | A. STATE <u>md</u> B. COUNTY <u>9-07</u> | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>1517 Homestead St</u> | | | |
| 5. SEX <u>F</u> | 6. RACE <u>Negro</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH <u>8/16/04</u> | 9. AGE (In years lost birthday) <u>61</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (state or foreign country) <u>North Carolina</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Sandy Pointer</u> | | 14. MOTHER'S MAIDEN NAME <u>Vinnie Carter</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT ADDRESS <u>Corea Fields 1517 Homestead</u> | |
| 18. <u>28651</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | CAUSE OF DEATH (A) <u>BROCHOPNEUMONIA</u> DUE TO (B) <u>Dehydration</u> DUE TO (C) <u>Malnutrition</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>NONE</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u> | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <u>N/A</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>N/A</u> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>N/A</u> | |
| 21D. TIME OF INJURY (APPROX.) <u>N/A</u> | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> <u>N/A</u> | | 21F. HOW DID INJURY OCCUR? <u>N/A</u> | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9/17/65</u> 19 to <u>9/22/65</u> 19 that (I) <u>last</u> saw the deceased alive on <u>12 30 AM</u> 19 <u>9/22/65</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>did</u> (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Brian J. Baldwin, M.D.</u> | | M.D. Attending <input type="checkbox"/> Phys. Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>9/22/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>BRIAN J. Baldwin</u> | | 23D. ADDRESS <u>UNIVERSITY HOSPITAL</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9/26/65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cem</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Balt. Md.</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 24 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>WM MARCH 928 E North Ave</u> | |

04-01

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|------------------------------------------------------------------------------|------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT | | BIRTH NO. 65 9804 | | CERTIFICATE OF DEATH | | Registered No. 65 9804 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Louis Stagg | | | | 2. DATE AND HOUR OF DEATH 9-21-65 4:24 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 8-07 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2033 Mura Street | | | |
| 5. SEX FEMALE | 6. RACE COLORED | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SEPARATED | 8. DATE OF BIRTH 10-30-13 | 9. AGE (In years last birthday) 50 51 | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME JOHN ELLIOTT | | | 14. MOTHER'S MAIDEN NAME PEARL WILKENS | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Wilbert Elliott 2025 E. Preston St. | | |
| 18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) respiratory arrest DUE TO (B) cerebral hemorrhage DUE TO (C) | | | | INTERVAL BETWEEN ONSET AND DEATH 3 weeks | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 3/8/31+9/1 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED gastrointestinal bleeding | | 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/31 1965 to 9/21 1965 , that (I) (we) last saw the deceased alive on 9/21/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Edward Tarlor | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-21-65 | |
| 23C. PHYSICIAN'S NAME (Type) Edward Tarlor | | 23D. ADDRESS The Johns Hopkins Hospital | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/25/65 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem. | | 24D. LOCATION (City, town, or county) (State) Ann Arundel Cty. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 24 1965 | | 25B. NAME OF REGISTRAR Robert E. Tarlor | | 25C. FUNERAL DIRECTOR WM MARCH | | 25D. ADDRESS 928 E. North Ave. | |



1

65 9805

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 9805

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) BESSIE TYLER

2. DATE AND HOUR PRONOUNCED DEAD 9/16/65 4:35a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 17-02

D. STREET ADDRESS (If rural, give location) 1205 Argyle Ave

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital

5. SEX female

6. RACE colored

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH Oct 1, 1884

9. AGE (In years last birthday) 80

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caterer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Joshua Bundy

14. MOTHER'S MAIDEN NAME Adeline Bundy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Miss Clara Tyler 1205 Argyle Ave.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Carcinoma of endometrium with metastases

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No) no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)

21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE Werner U. Spitz M.D.

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

ASSOCIATE MEDICAL EXAMINER

DATE SIGNED 9/16/65

23A. BURIAL CREMATION, REMOVAL (Specify) Burial

23B. DATE 9/20/65

23C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetery

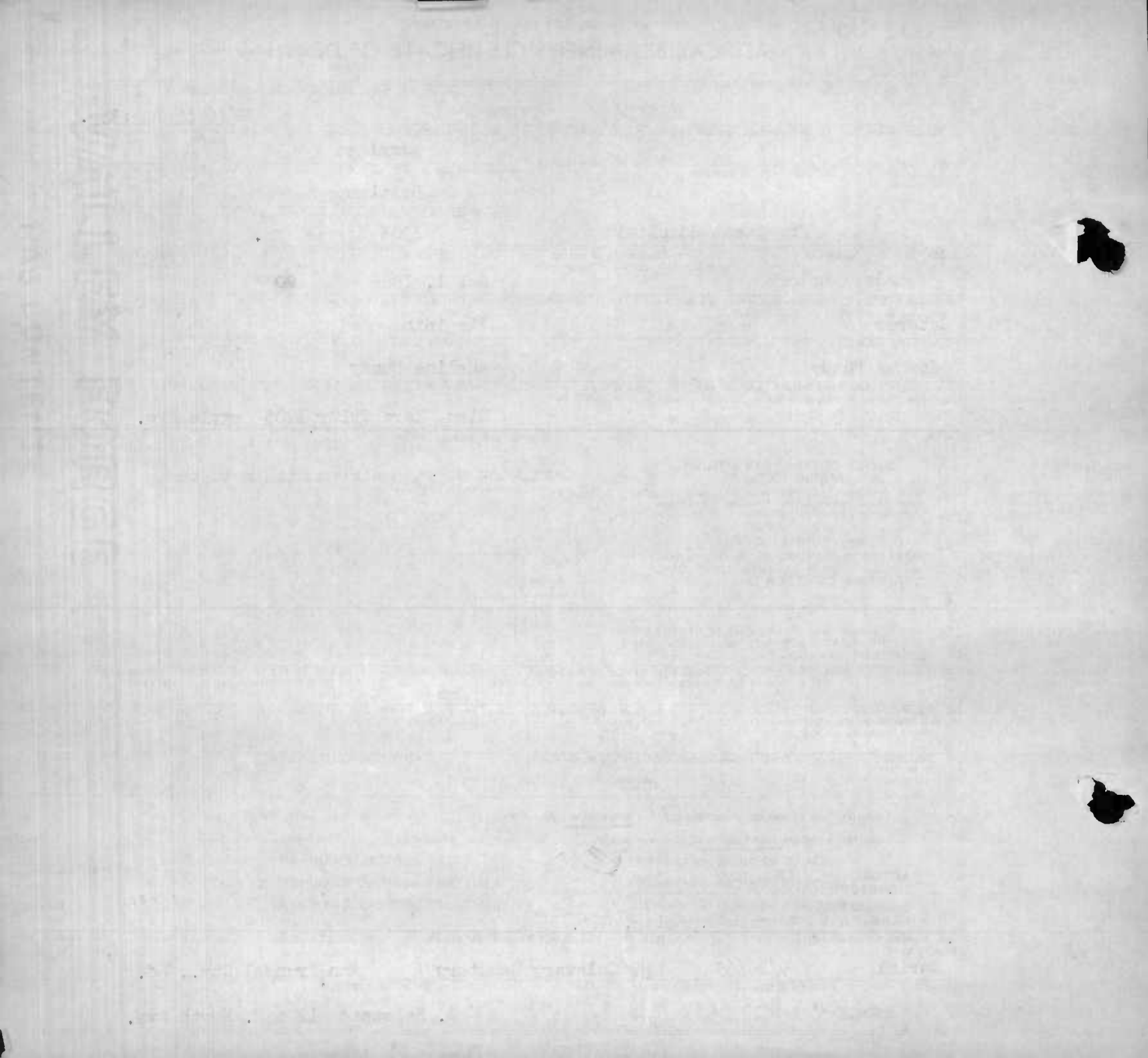
23D. LOCATION (City, town, or county) (State) Ann Arundel Cty., Md.

24A. DATE REC'D BY HEALTH DEPT. SEP-24 1965

24B. NAME OF REGISTRAR Robert E. Falek M.D.

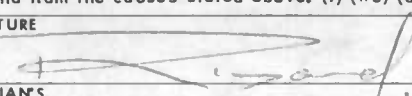
24C. FUNERAL DIRECTOR A. Halstead 1206 W. North Ave.

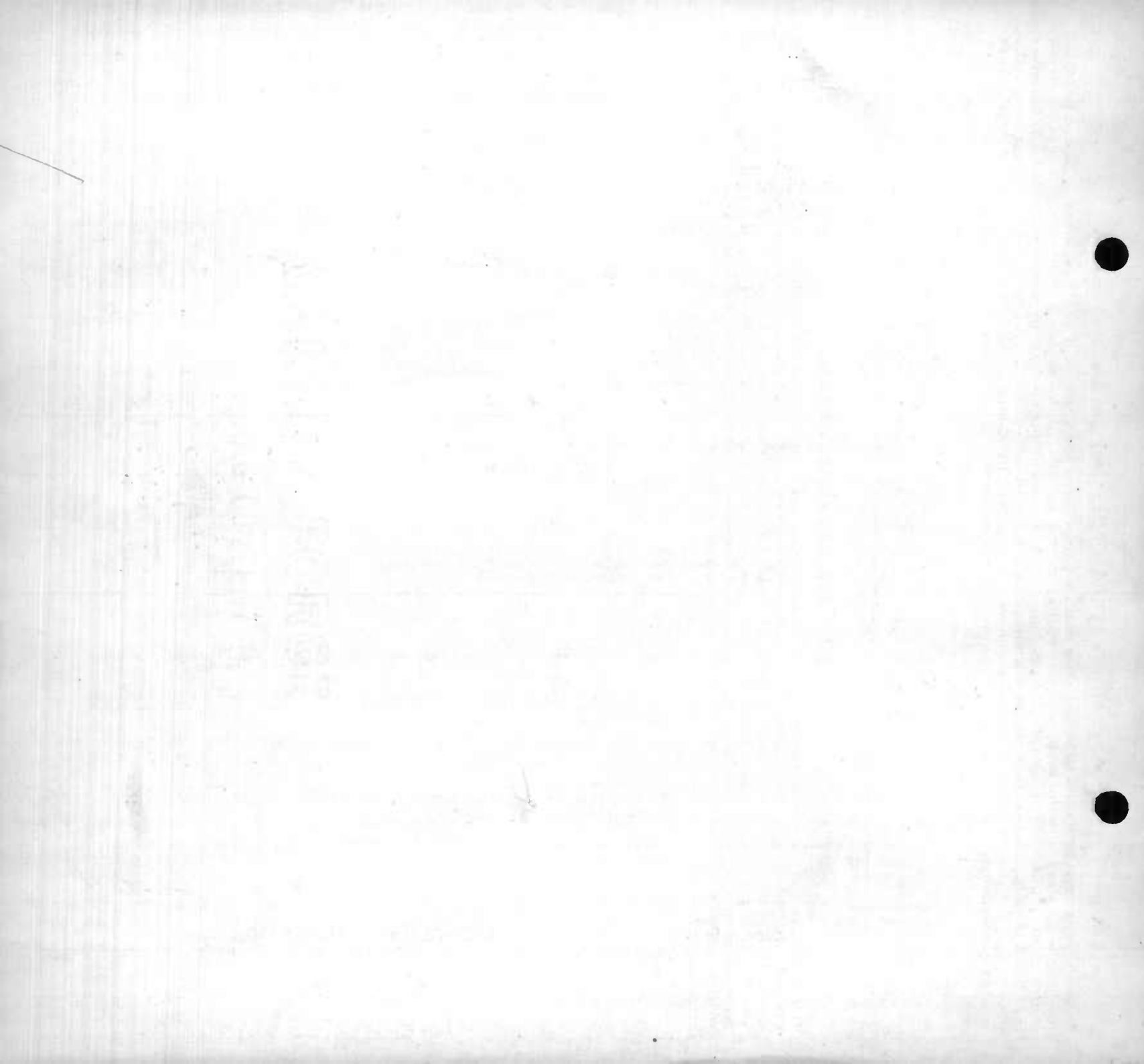
VS 151-REV. 1/1/65



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

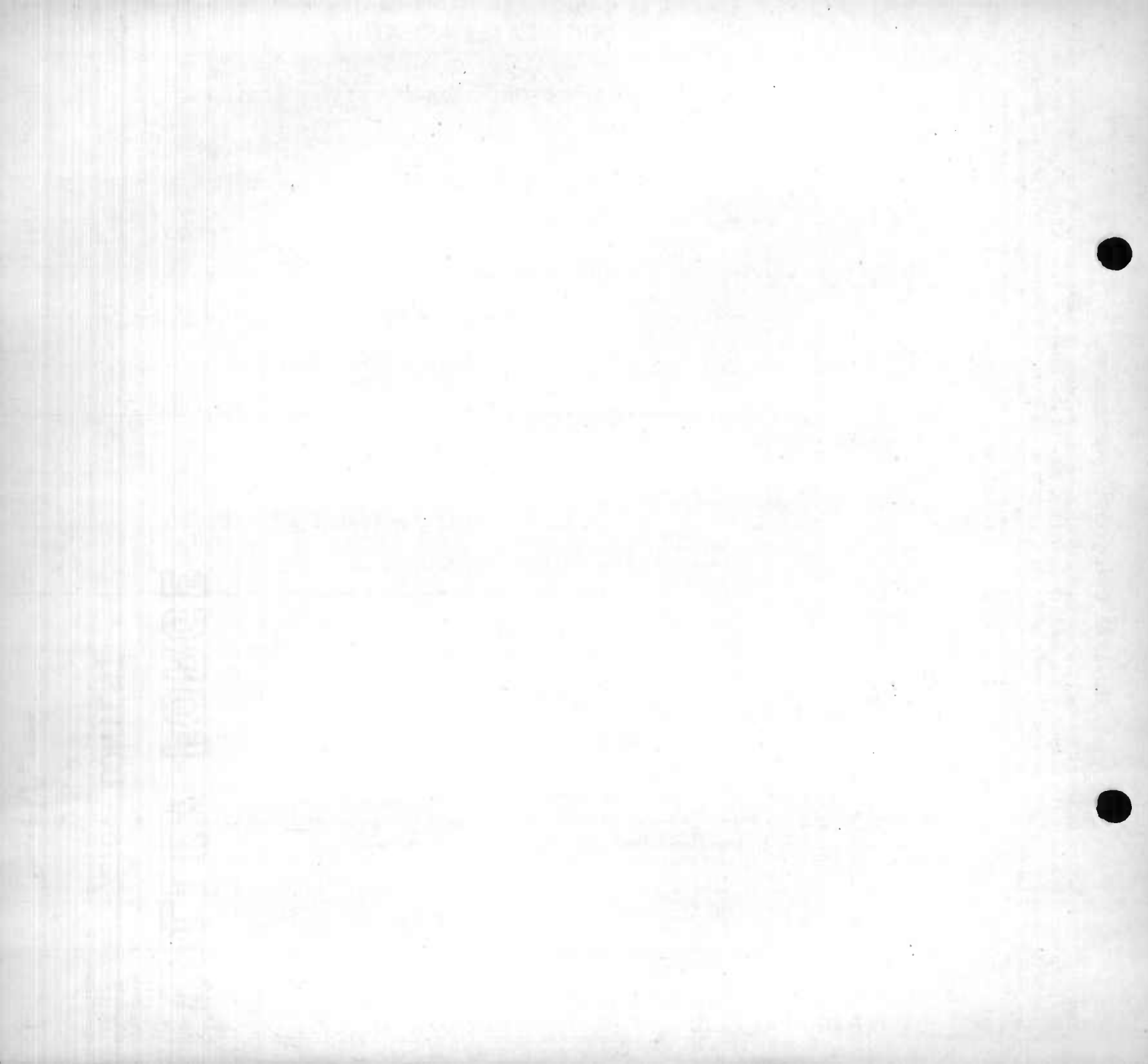
| BIRTH NO. 65 9806 | | | | Baltimore City Health Department | | Registered No. 65 9806 | |
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| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Brooks, Florence | | | | 2. DATE AND HOUR OF DEATH September 22, 1965 3:30 a.m. | | | |
| 3. PLACE OF DEATH BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1304 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| D. STREET ADDRESS (If rural, give location) 1712 Gwynns Falls Parkway | | | | | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH March 18, 1907 | 9. AGE (In years last birthday) 58 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Ind. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Lloyd Brooks | | | | 14. MOTHER'S MAIDEN NAME Rachel Toy | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Amblee Upsher | | ADDRESS 3837 Woodbrook Ave | |
| 18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osseous, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Cerebral Hemorrhage DUE TO (B) HASCVD DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from September 20, 1965 to September 22, 1965 , that (I) (we) last saw the deceased alive on September 22, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE  23C. PHYSICIAN'S NAME (Type) Andre Rigaud | | | | | | 23B. DATE SIGNED 9-22-65 | |
| 23D. ADDRESS M.D. 1514 Division Street | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE 9-25-65 | | 24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Ch. Arbutus, Md. | | 24D. LOCATION (City, town, or county) (State) Arbutus, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 24 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR George A. Kline | | ADDRESS 1548 N. Calhoun St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

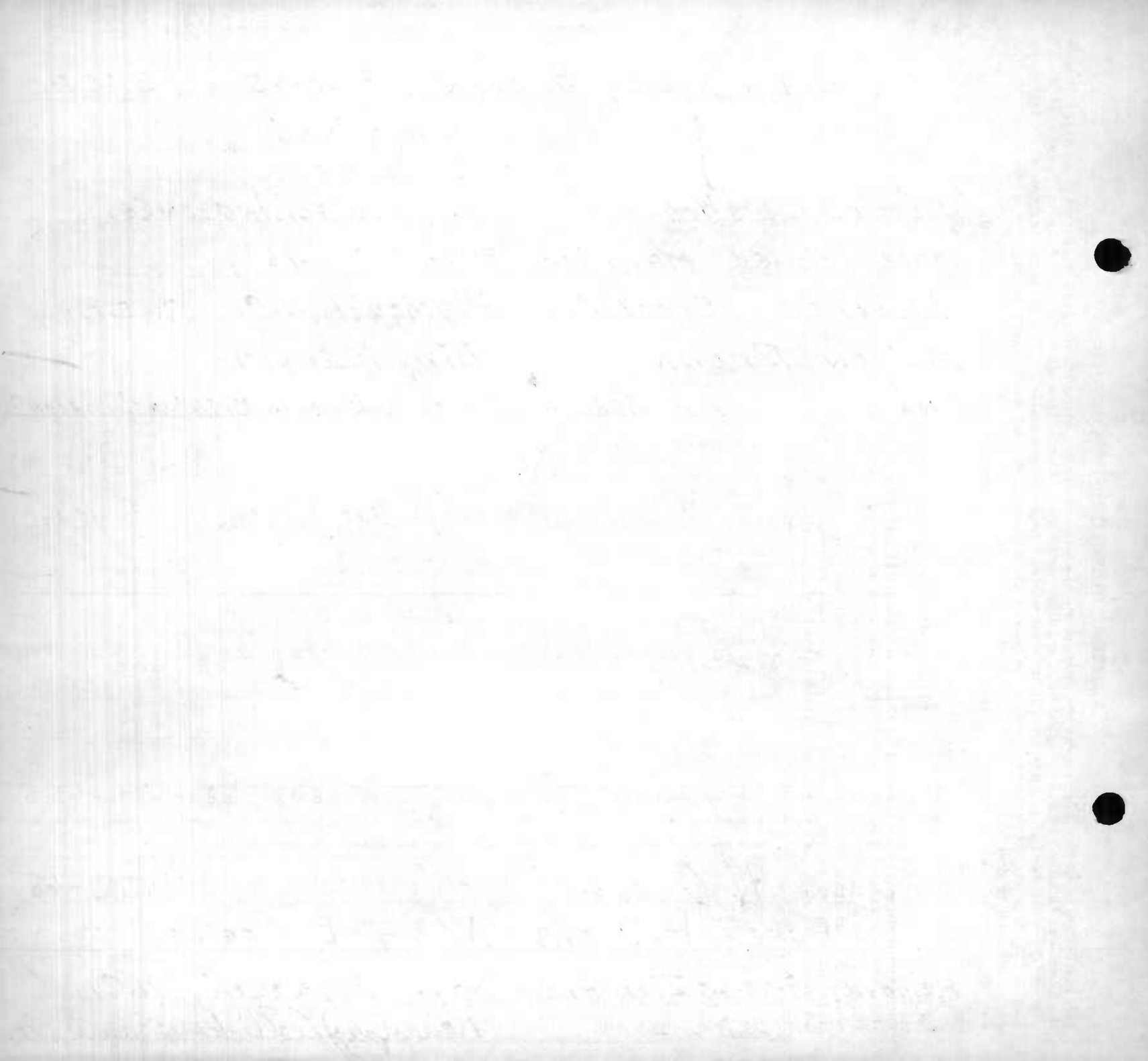
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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|----------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. 65 9807 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9807 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <i>BERDIE Dorsey (Bertie)</i> | | 2. DATE AND HOUR OF DEATH <i>9/21/65 10:20 M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Lutheran Hospital of Maryland</i> | | A. STATE <i>Maryland</i> B. COUNTY <i>15-04</i> | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | |
| | | D. STREET ADDRESS (If rural, give location) <i>2109 N. Smallwood</i> | | | |
| 5. SEX <i>F</i> | 6. RACE <i>Negro</i> | 7. MARRIED; NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i> | 8. DATE OF BIRTH <i>9/2/93</i> | 9. AGE (In years lost birthday) <i>72</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Va.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | | |
| 13. FATHER'S NAME <i>Samuel Morris</i> | | | 14. MOTHER'S MAIDEN NAME <i>Matilda Ruffin</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Alberta Howell 3114 Presstman St</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>332X1</i> | | CAUSE OF DEATH (A) <i>Cerebro Vascular Thrombosis</i> DUE TO (B) <i>Hypertension</i> DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9/20</i> 19 <i>65</i> to <i>9/21</i> 19 <i>65</i> , that (I) <i>we</i> last saw the deceased alive on <i>9/21</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <i>did</i> (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Inia C. Espina</i> | | | | 23B. DATE SIGNED <i>9/21/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>INIA C. ESPINA</i> | | | | 23D. ADDRESS <i>Lutheran Hospital of Maryland</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>9-21-65</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Mt Auburn Cem.</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 24 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Farley, M.D.</i> | | 25C. FUNERAL DIRECTOR <i>George A. Kilm 1348 N. Calhoun St.</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 3808 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9808 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| John Wesley Brown | | 9-20-65 | | 3:00 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| St. Joseph's Hospital | | Maryland 8-07 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 1219 N. Washington St. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| Male | Colored | Married | 3-17-1919 | 46 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Laborer | | Steel Co. | | Plymouth, N.C. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Milton Brown | | Ainy Martin | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | 238-22-1055 | | Helen M. Brown | |
| 18. 4-20-11 | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | Acute Myocardial Infarction Instant | |
| ANTECEDENT CAUSES | | (B) DUE TO | | Coronary Artery Disease 5 years | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1960 to 9-20-1965, that (H) (we) last saw the deceased alive on 9-3-1965 and that (In my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| Eugene H. Owens | | 9-22-65 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Eugene H. Owens | | 1735 E. Federal St. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Removal | | 9-22-65 | | Zion Grave Cntry. | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. NAME OF REGISTRAR | | 24F. FUNERAL DIRECTOR | |
| Plymouth, N.C. | | Robert E. Farley | | Randolph J. Collick | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| SEP 24 1965 | | Robert E. Farley | | Randolph J. Collick | |
| | | | | 1412 E. Preston St. | |



| 65 9809 | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 9809 | |
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| BIRTH NO. | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | ANNIE SIMMONS | | 2. DATE AND HOUR PRONOUNCED DEAD September 22, 1965 4:55 A.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital | | A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 721 N. Caroline Street | | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH April 6, 1919 | 9. AGE (In years last birthday) 45 | If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) N.C. | |
| 13. FATHER'S NAME John Richardson | | 14. MOTHER'S MAIDEN NAME SALLIE SMITH | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS MOSES SIMMONS 721 N. CAROLINE ST | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) E983X MASSIVE 3D DEGREE BODY BURNS. | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 721 N. Caroline Street | |
| 21D. TIME OF INJURY (APPROX.) 8 3 '65 P | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Clothing deliberately set afire. | |
| 22. I certify that I held an Inquiry <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Petty, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 9/23/65 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 23B. DATE 9/25/65 | | 23C. NAME of CEMETERY or CREMATORY Mt. Calvary | |
| 23D. LOCATION (City, town, or county) (State) A.A. County Md | | 24A. DATE REC'D BY HEALTH DEPT. SEP 24 1965 | | | |
| 24B. NAME OF REGISTRAR Robert E. Fairbank | | 24C. FUNERAL DIRECTOR ADDRESS Joseph G. Locks 1304 N. Central Ave | | | |

WALTER BATES

Chas. S.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9810 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9810 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | X | |
| 1. NAME OF DECEASED (Type or Print) IDZIK, JAMES Or Stanislaus Idzik | | 2. DATE AND HOUR OF DEATH Sept 23, 1965 10:50 PM M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JENKINS MEMORIAL HOSPITAL 1000 S CATON AVENUE BALTIMORE, MD 21229 | | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21225 D. STREET ADDRESS (If rural, give location) 5500 Ritchie Highway | | | |
| 5. SEX M | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (specify) Never married | 8. DATE OF BIRTH 4-25-1896 | 9. AGE (In years lost birthday) 69 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OILER | | 10B. KIND OF BUSINESS OR INDUSTRY WEST. STEVEDORE CO | | 11. BIRTHPLACE (State or foreign country) POLAND | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME JOSEPH IDZIK | | 14. MOTHER'S MAIDEN NAME MARY CEBULA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 216-09-4677 | | 17. INFORMANT ADDRESS MEDICAL RECORDS ROOM OF JENKINS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH CVA cerebral arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH 8 days years | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic heart disease | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 9/23 1965 to 9/23 1965, that (2) (we) lost saw the deceased alive on 9/23 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. Raymond Gladue | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Sept. 23, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) J. RAYMOND GLADUE | | 23D. ADDRESS 3350 Wilkens Ave. 21229 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/27/65 | | 24C. NAME of CEMETERY or CREMATORY St. Stanislaus Cemetery | |
| 24D. LOCATION 6515 Boston St, Baltimore, Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 24 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley M.D. | | 25C. FUNERAL DIRECTOR George A. Weber - 705 S. Ann St. | |

Central Institution

State of New York

Department of Education

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9811 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9811 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) MAC DONALD, ALICE G. | | 2. DATE AND HOUR OF DEATH 9-21-65 11:50P M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 25-31 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE ZONE 29 D. STREET ADDRESS (If rural, give location) 400 RANDOM ROAD | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 6-23-91 | 9. AGE (In years last birthday) 74 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse | | 10B. KIND OF BUSINESS OR INDUSTRY Practical | | 11. BIRTHPLACE (State or foreign country) MARYLAND | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME GEORGE O. DAVIDSON | | 14. MOTHER'S MAIDEN NAME SALLY HALE | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. -----579-22-3164 | | 17. INFORMANT ADDRESS ST. AGNES RECORDS-CATON & WILKENS AVE | | | |
| 18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) <i>Acute myocardial Infarct.</i> DUE TO <i>with rupture of ventricle.</i> (B) <i>Cardiac Tamponade.</i> DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| MEDICAL CERTIFICATION 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>SEPTEMBER 21 1965</u> to <u>SEPTEMBER 21 1965</u> , that (I) (we) last saw the deceased alive on <u>SEPTEMBER 21 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Rafael Marin</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/22/65 | |
| 23C. PHYSICIAN'S NAME (Type) RAFAEL MARIN | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 25-Sept-65 | | 24C. NAME of CEMETERY or CREMATORY Cedar Hill Cemetery | |
| 24D. LOCATION Prince Georges Co., Maryland | | 25A. DATE REC'D BY HEALTH DEPT. SEP 24 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR J. B. Whipple, Jr. - 1300 East Ave | | | |

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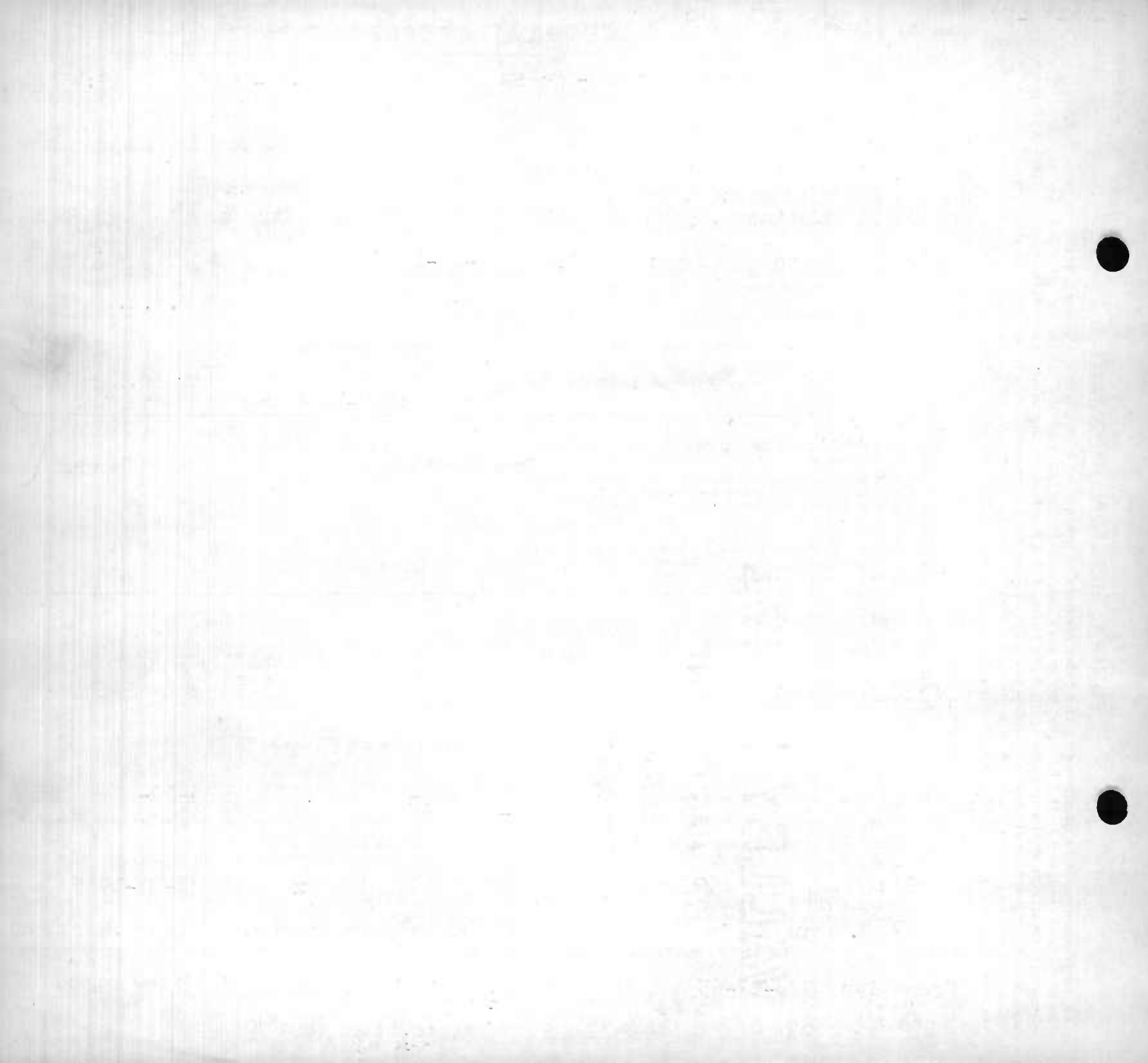
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
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| M2541 BIRTH NO. 3812 | | | | | CERTIFICATE OF DEATH | | | Registered No. 65 9812 | |
| 1. NAME OF DECEASED (Type or Print) MAGNOLI, MR. ALBERT B. | | | | | 2. DATE AND HOUR OF DEATH September 22, 1965 3:00 A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph Hospital | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 26-10 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 229 S. Clinton Street - 21224 | | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH 3-25-98 | 9. AGE (In years last birthday) 67 | If Under 1 Yr. Months: Days: Hours: Min. | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian - City of Balto. | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Benedict Magnolia | | | | | 14. MOTHER'S MAIDEN NAME Elsie D. Palma | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. 220-4-3806 | | 17. INFORMANT Mrs Paul Gantz | | | ADDRESS 211 S. Clinton St | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction (A) DUE TO ANTECEDENT CAUSES (B) DUE TO Cerebral Embolism (C) DUE TO DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) None | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept. 16, 1965 to Sept. 22, 1965 , that (I) (we) last saw the deceased alive on Sept. 22, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Jose D. Manalo M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | | | | | 23B. DATE SIGNED Sept. 22, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Jose D. Manalo | | | 23D. ADDRESS 1400 N. Caroline Street - 21213 | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Sept 25, 1965 | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer | | | 24D. LOCATION (City, town, or county) (State) Beltz Rd Balto Md | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 24 1965 | | | 25B. NAME OF REGISTRAR Robert E. Farley | | | 25C. FUNERAL DIRECTOR Joseph H. Jernigan ADDRESS 263 S. Clarking St | | | |

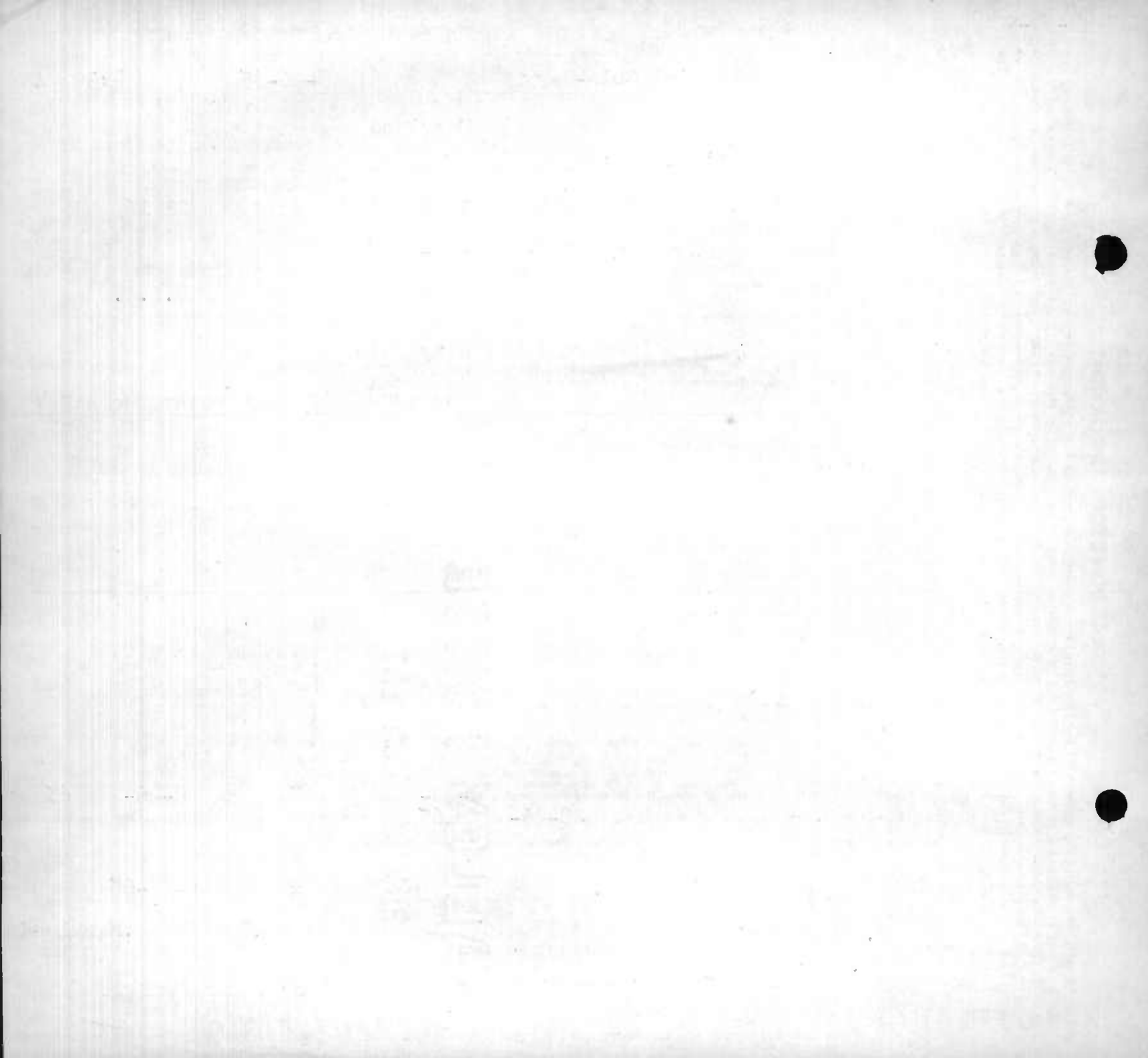
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9813 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9813 4 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | | |
| (Type or Print) | | | | Baby Boy Dukes-Evelyn | | | |
| 2. DATE AND HOUR OF DEATH | | | | 8-20-1965 2:45 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| Baltimore City Hospitals 4940 Eastern Avenue Baltimore Maryland 21224 | | | | Maryland 21-01 | | | |
| 5. SEX | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| Male | | | | Baltimore | | | |
| 6. RACE | | | | D. STREET ADDRESS (If rural, give location) | | | |
| Negro | | | | 933 South Paca Street 21230 | | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | | | 8. DATE OF BIRTH | | | |
| Never Married | | | | 8-20-1965 | | | |
| 9. AGE (In years last birthday) | | | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | |
| 3 | | | | | | | |
| 11. BIRTHPLACE (State or foreign country) | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| Maryland | | | | U.S.A. | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| | | | | Evelyn Dukes | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| | | | | | | | |
| 17. INFORMANT | | | | ADDRESS | | | |
| Records: BCH-4940 | | | | Baltimore, Maryland 4940 Eastern Avenue, | | | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | 3 hours | | | |
| (This does not mean the mode of dying, e.g., heart failure, osihenio, etc. It means the disease, injury or complication which caused death.) | | | | (A) Immaturity DUE TO | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 2 | | | | Yes | | Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-20-19 65 to 8-20-19 65, that (I) (we) last saw the deceased alive on 8-20-19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| S. Wayne Klein M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 8-20-1965 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| S. Wayne Klein M.D. | | | | 4940 Eastern Avenue, Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Cremation | | 8-27-65 | | Baltimore City Hospitals | | Baltimore, Maryland 21224 | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| SEP 24 1965 | | Robert E. Taylor | | HOSPITAL DISPOSAL | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

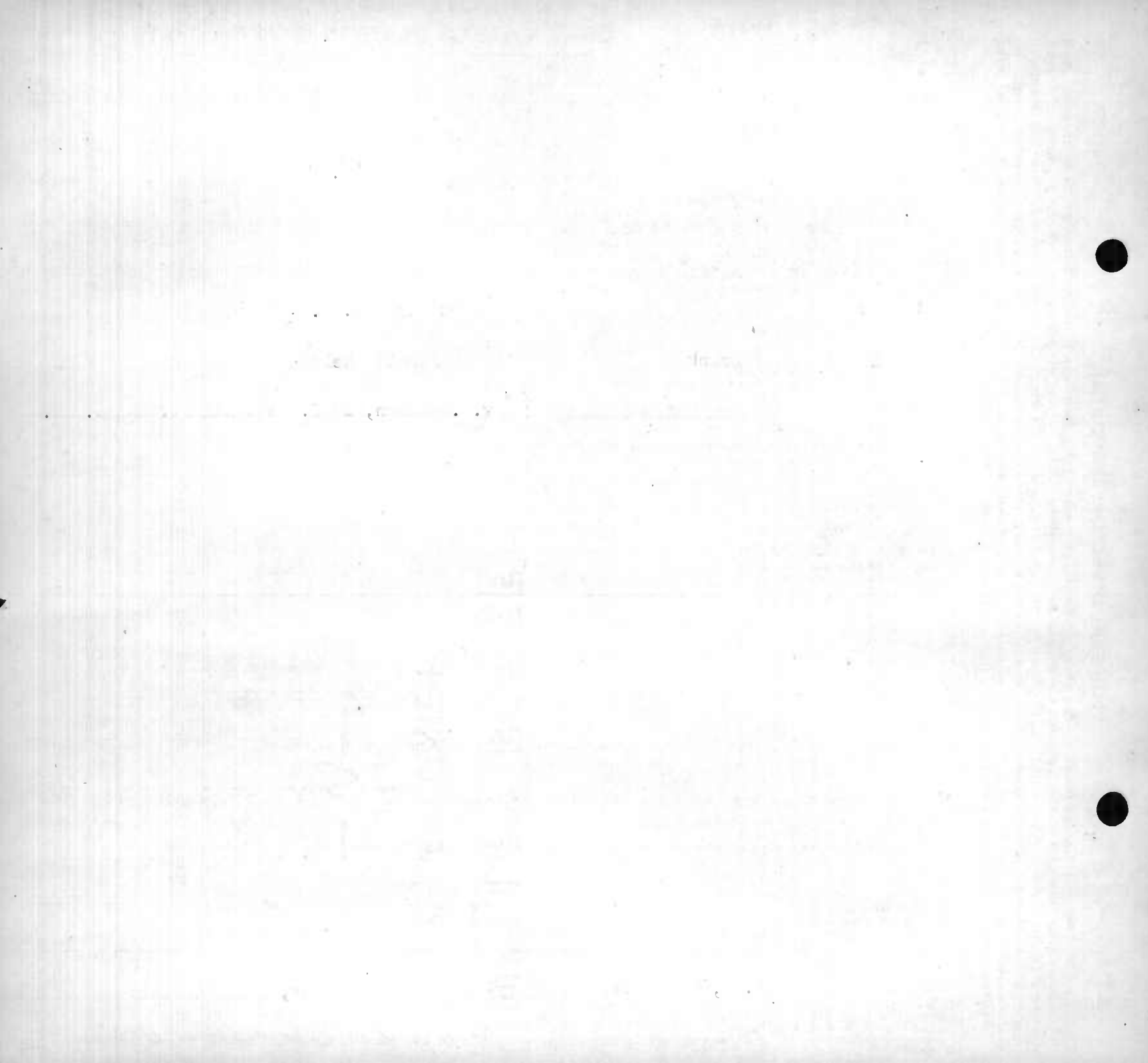
| BIRTH NO. 65-2101765 9814 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9814 | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--------------------------------------------------------------------------------------------|--|------------------------|--|
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| Baby Girl Cole-Mary | | | | 8-26-65 4:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | | Maryland 15-09 | | | |
| 5. SEX | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| Female | | | | Baltimore | | | |
| 6. RACE | | | | D. STREET ADDRESS (If rural, give location) | | | |
| Negro | | | | 3903 Fairfax Road 21216 | | | |
| 7. MARRIED; NEVER MARRIED WIDOWED, DIVORCED (specify) | | | | 8. DATE OF BIRTH | | | |
| Never married | | | | 8-25-1965 | | | |
| 9. AGE (In years lost birthday) | | | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | |
| 9 | | | | | | | |
| 11. BIRTHPLACE (State or foreign country) | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| Maryland | | | | U.S.A. | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| | | | | Mary Cole | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| | | | | 17. INFORMANT ADDRESS | | | |
| | | | | Records: BCH-4940 Eastern Avenue 21224 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) Premature | | | |
| ANTECEDENT CAUSES | | | | (B) Respiratory Distress Syndrome | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 2 | | | | 20A. AUTOPSY? (Yes or No) | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| 21C. WHERE DID INJURY OCCUR? | | | | (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED | | | |
| | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-25-1965 to 8-26-1965, that (I) (we) last saw the deceased alive on 8-26-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| S. Wayne Klein | | | | 8-26-65 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| S. Wayne Klein | | | | M.D. 4940 Eastern Avenue, Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | | |
| Cremation | | | | 8-27-65 | | | |
| 24C. NAME OF CEMETERY or CREMATORY | | | | 24D. LOCATION (City, town, or county) (State) | | | |
| Baltimore City Hospitals | | | | Baltimore, Maryland 21224 | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | | |
| SEP 24 1965 | | | | HOSPITAL DISPOSAL | | | |
| 25C. FUNERAL DIRECTOR | | | | ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9815 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|---------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 65 9815 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) LARRICK, VERNIE | | 2. DATE AND HOUR OF DEATH SEPTEMBER 23, 1965 11:40 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 53-00 | |
| FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL OF MARYLAND | | D. STREET ADDRESS (If rural, give location) 401 FOURTH AVENUE | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 7-16-1876 | 9. AGE (In years last birthday) 89 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Hampshire Co. W. Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME Samuel Frank | | 14. MOTHER'S MAIDEN NAME Fannie Reid | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT C.R. Johnson, 116 S. Bentalow St. Balto. md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) TERMINAL BRONCHO PNEUMONIA by ATELECTASIS | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH 8 days | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | (B) DUE TO | |
| (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | ARTIC INSUFFICIENCY | | | |
| 19A. DATE OF OPERATION SEPT 14 / 1965 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ACUTE GALLBLADDER DISEASE | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from September 11 19 65 to September 23 19 65 , that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Dahlin Quijada | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/23/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE Sept. 27, 65 | | 24C. NAME OF CEMETERY or CREMATORY Shiloh Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Lehew, West Virginia | | 25A. DATE REC'D BY HEALTH DEPT. SEP 24 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | |
| 25C. FUNERAL DIRECTOR Wm. J. Zickner & Sons, Baltimore | | 25D. ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. 65 9816 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9816 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Hanson, Dora Beatrice</i> | | 2. DATE AND HOUR OF DEATH <i>9/21/65 7:22 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>The Union Memorial Hospital</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 63700</i> | | D. STREET ADDRESS (If rural, give location) <i>914 Milford Mill Road 8</i> | |
| 5. SEX <i>Female</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i> | 8. DATE OF BIRTH <i>7/14/92</i> | 9. AGE (In years last birthday) <i>73</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Virginia</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>William Bryant</i> | | 14. MOTHER'S MAIDEN NAME <i>Madora Ficklin</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No None</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Mr. Roy Hanson</i> ADDRESS <i>Same as above</i> | |
| 18. <i>443X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <i>Renal Failure = Ureterolithiasis</i> (B) <i>Chronic Pyelonephritis</i> (C) <i>Hypertensive Cardiovascular Disease ? years = Heart Failure</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (this hospital) attended the deceased from <i>9-19</i> 19 <i>65</i> to <i>9-21</i> 19 <i>65</i> , that (we) last saw the deceased alive on <i>9-21</i> 19 <i>65</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <i>A. C. Timon, Jr.</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>9/21/65</i> | |
| 23C. PHYSICIAN'S NAME (Print) <i>ANCEL C. TIMON, JR.</i> | | M.D. <i>Union Memorial Hospital</i> | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>9/24/1965</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Druid Ridge Cemetery</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>Pikesville, Maryland</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 24 1965</i> | | 25B. NAME OF REGISTRAR <i>R. E. Falek</i> | |
| 25C. FUNERAL DIRECTOR <i>Wm. J. Dickner & Sons</i> | | ADDRESS <i>Balto., Md. 17 North Pa. Ave.</i> | | | |

U. S. DEPARTMENT OF AGRICULTURE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9817 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9817 | |
| M.E. CASE NO. | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) G. Everett Siebert | | | 2. DATE AND HOUR OF DEATH September 21, 1965 M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 213 St. Dunstons Road Baltimore, Maryland 21212 | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) 213 St. Dunstons Road 12 | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 11/19/1890 | 9. AGE (In years last birthday) 74 | 10. If Under 1 Yr. Months Days 11. If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney - Self | | 10B. KIND OF BUSINESS OR INDUSTRY Attorney | | 11. BIRTHPLACE (State or foreign country) New York City | |
| 13. FATHER'S NAME William M. Siebert | | | 14. MOTHER'S MAIDEN NAME Louise Haush | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None | | | 17. INFORMANT Mrs. Marguerite E. Siebert | | |
| 16. SOCIAL SECURITY NO. None | | | 213 St. Dunstons Rd. Baltimore, Md. 12 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, ashenia, etc. It means the disease or injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH ARTERIO SCLEROTIC HEART DISEASE DUE TO MYOCARDIAL INFARCTION TUMOR 1951 FRACTURED FEMUR | | |
| 19A. DATE OF OPERATION 0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | |
| 20A. AUTOPSY? (Yes or No) No | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 6-15 1965 to 9-26 1965, that (I) (we) lost saw the deceased alive on 9-19 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. Nelson Carey | | | 23B. DATE SIGNED 9-22-1965 | | |
| 23C. PHYSICIAN'S NAME (Type) T. NELSON CAREY | | | 23D. ADDRESS 11 E. CHASE ST. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/23/1965 | | 24C. NAME of CEMETERY or CREMATORY Druid Ridge Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Pikesville, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. SEP 24 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR Wm. J. Fisher Sons North & A. Ave. Balto., Md. | | | |



THE UNIVERSITY OF CHICAGO

LIBRARY

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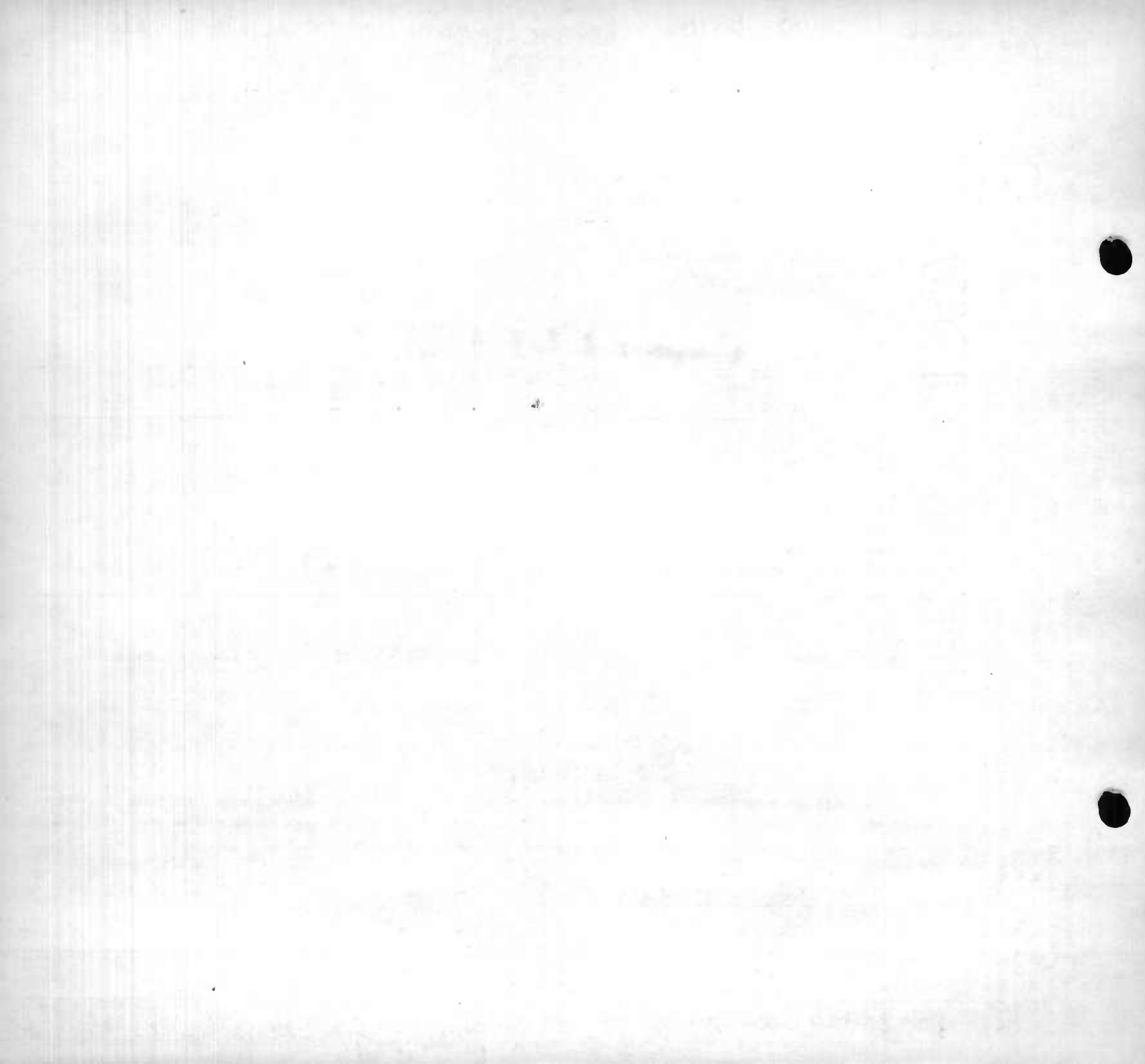
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9818 | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|------------------------------------------------------------------------|
| BIRTH NO. 65 9818 | | | CERTIFICATE OF DEATH | | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH September 21, 1965 | | |
| 1. NAME OF DECEASED (Type or Print) Rebecca G. Engel | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 27-15 | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) House in the Pines - Belvedere 2525 West Belvedere Avenue Baltimore, Maryland 21215 | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) 2301 South Road 21209 | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH May 30, 1867 | 9. AGE (In years last birthday) 98 | If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME Aaron Goodman | | | 14. MOTHER'S MAIDEN NAME Rosalie Behrend | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | 17. INFORMANT ADDRESS 2301 South Road Mr. Jay G. Engel Baltimore, Maryland 9 | | |
| 18. 450.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arterio-Sclerosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Senility | | | CAUSE OF DEATH (A) Arterio-Sclerosis DUE TO (B) Senility DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 10 years 10 years |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from June 1 19 20 to Sept 21 19 65 , that (I) (we) last saw the deceased alive on Sept 21 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Erwin E. Mayer M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 23B. DATE SIGNED Sept 22 1965 | |
| 23C. PHYSICIAN'S NAME (Type) ERWIN E. MAYER M.D. | | | | 23D. ADDRESS The Esplanade | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/23/1965 | | 24C. NAME OF CEMETERY or CREMATORY Oheb Shalom Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 24 1965 | | 25B. NAME OF REGISTRAR Robert E. [unclear] | | 25C. FUNERAL DIRECTOR ADDRESS Wm. J. [unclear] + sons Balto., Md. 17 North Pa. ave. | |



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FUNERAL DIRECTOR: IMPORTANT

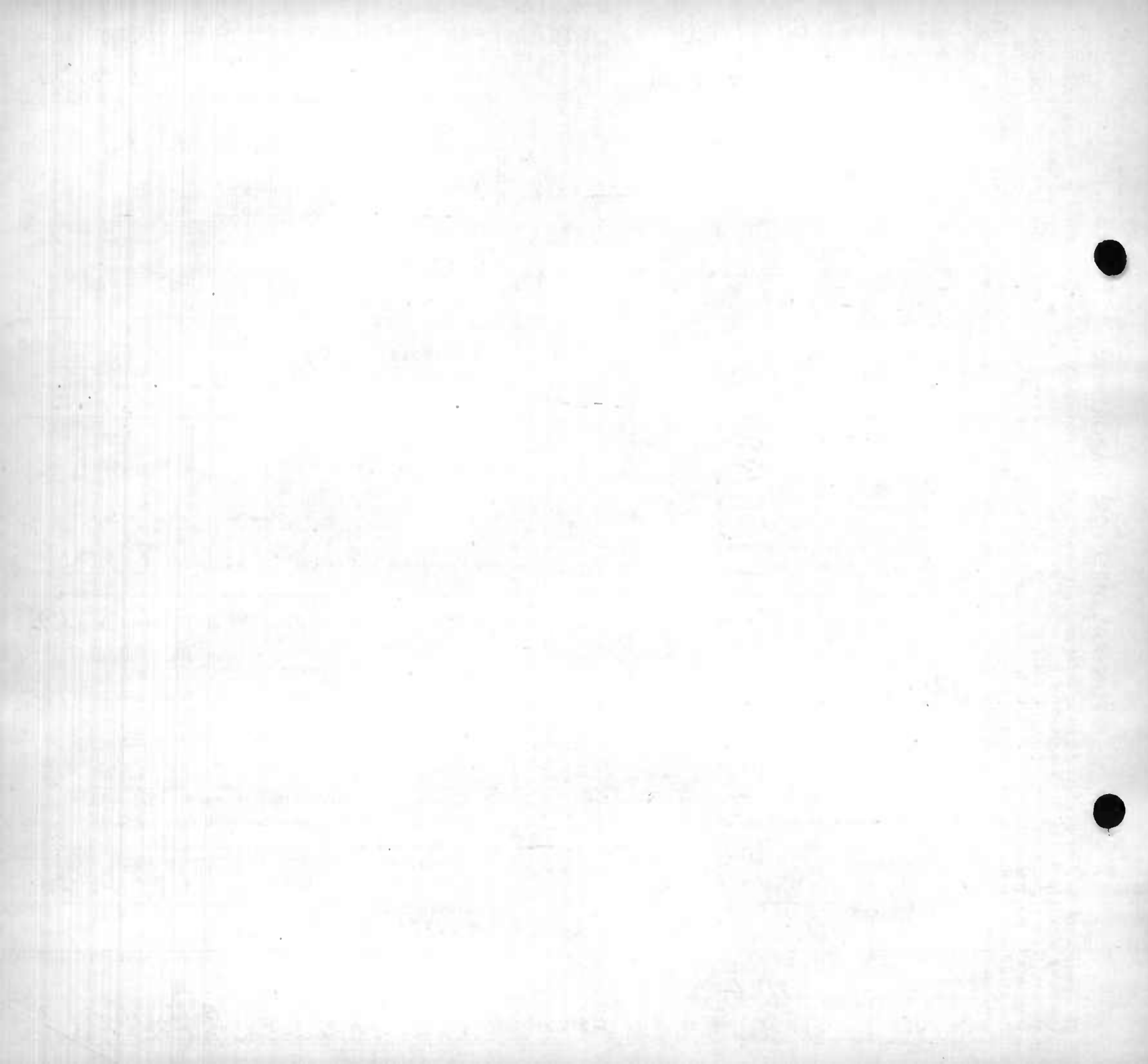
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. 65 9819 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9819 | |
| M.E. CASE NO. | | | 1. NAME OF DECEASED (Type or Print) Lucy P. Rhodes | | |
| 2. DATE AND HOUR OF DEATH 9-21-1965 3:40 A.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | A. STATE Maryland B. COUNTY 27-17 | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | D. STREET ADDRESS (If rural, give location) 15321 Maple Avenue 15 Baltimore City | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 11-29-1883 | 9. AGE (In years last birthday) 81 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Wm. H. Hultz | | | 14. MOTHER'S MAIDEN NAME Lucille ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None | | 16. SOCIAL SECURITY NO. 213-54-0335 | 17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224 | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 443X I Congestive Heart Failure with Pulmonary Edema Hypertensive Arterio Sclerotic Heart Disease | | | INTERVAL BETWEEN ONSET AND DEATH 4 days ? years | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) Yes | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (APPROX.) | (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-4-19 64 to 9-21-19 65, that (I) (we) lost saw the deceased alive on 9-21-19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Allen Johnson M.D. | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-21-1965 |
| 23C. PHYSICIAN'S NAME (Type) Allen Johnson | | | 23D. ADDRESS Maryland 4940 Eastern Avenue, Baltimore, M.D. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9/23/1965 | 24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery | | 24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 24 1965 | | 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR Wm. J. Tichner & Sons Baltimore Md. 17 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

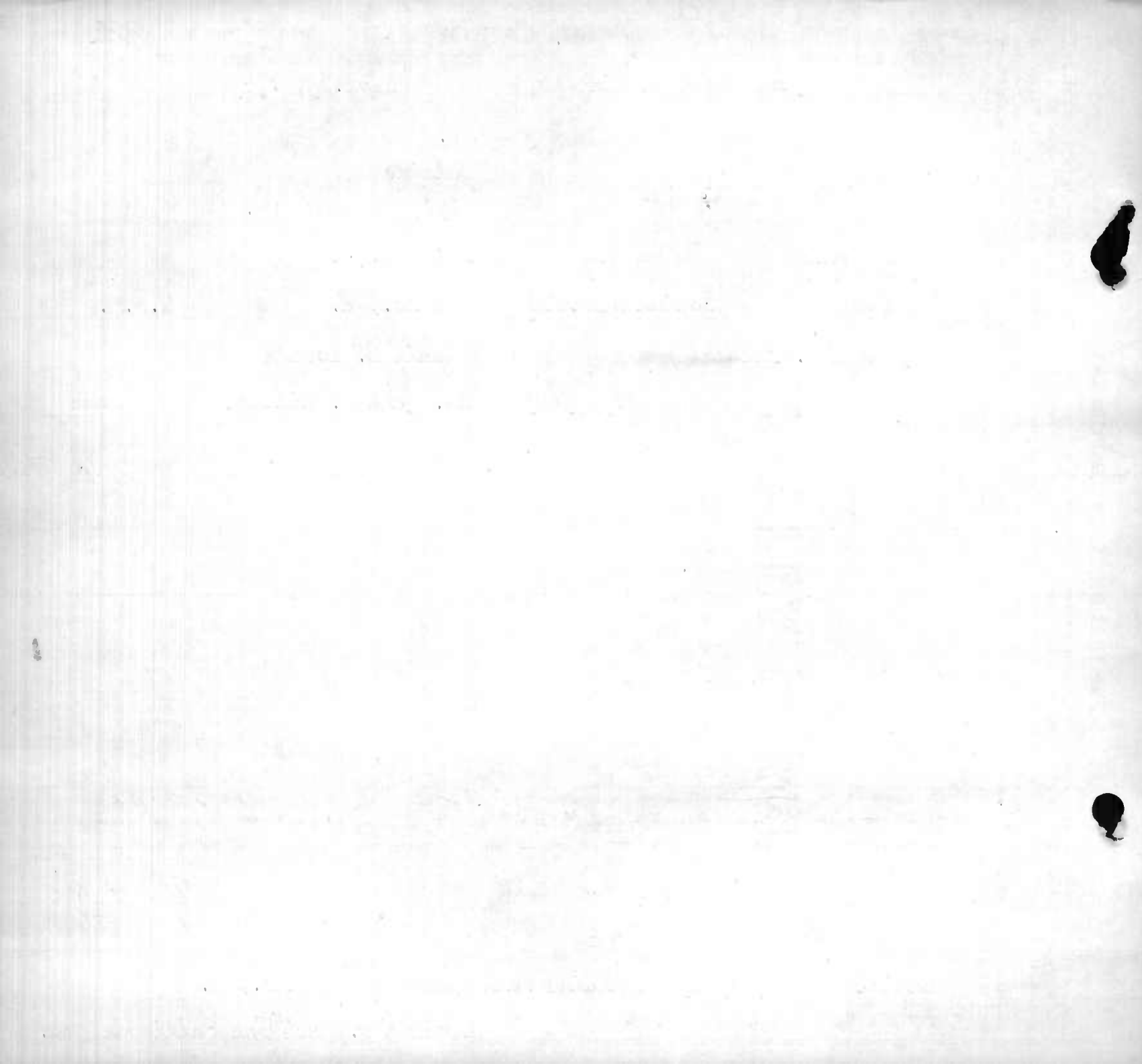
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------------------|-----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|--------------------------------|--|--|
| BIRTH NO. 65 9820 | | CERTIFICATE OF DEATH | | | | Registered No. 65 9820 | | | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) James Oscar Wroten | | | | | 2. DATE AND HOUR OF DEATH Sept 21-65 7:15 PM-M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1917 East 32nd Street Baltimore, Maryland 21218 | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 9-06 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1917 East 32nd Street 18 | | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 2/24/1884 | 9. AGE (In years last birthday) 81 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Sup't | | | 10B. KIND OF BUSINESS OR INDUSTRY Lumber | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13. FATHER'S NAME Webb Wroten | | | | | 14. MOTHER'S MAIDEN NAME Margaret Willey | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None | | | 16. SOCIAL SECURITY NO. 214-18-9564 | | 17. INFORMANT Mrs. Anne Peters Wroten 1917 E. 32nd St. Baltimore, Md. 18 | | | | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Coronary Thrombosis (B) Generalized arteriosclerosis (C) Cardiovascular Renal Disease | | | | | INTERVAL BETWEEN ONSET AND DEATH Immediate Long standing. Long standing | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Previous attack of Coronary Thrombosis Feb 21-62 | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 19 52 to Sept 21-65 19 52 and that (I) (we) last saw the deceased alive on Sept 21 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Nathaniel M Beck | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Sept 22-65 | | |
| 23C. PHYSICIAN'S NAME (Type) Nathaniel M Beck | | | | | 23D. ADDRESS 2818 St Paul St Baltimore *18 md | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/24/1965 | | 24C. NAME of CEMETERY or CREMATORY Lorraine Park Cemetery | | 24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 24 1965 | | 25B. NAME OF REGISTRAR Robert E. Fairbank | | 25C. FUNERAL DIRECTOR Wm. J. Tichner & Son | | 25D. ADDRESS Baltimore, Md. 17 North St. Ave. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

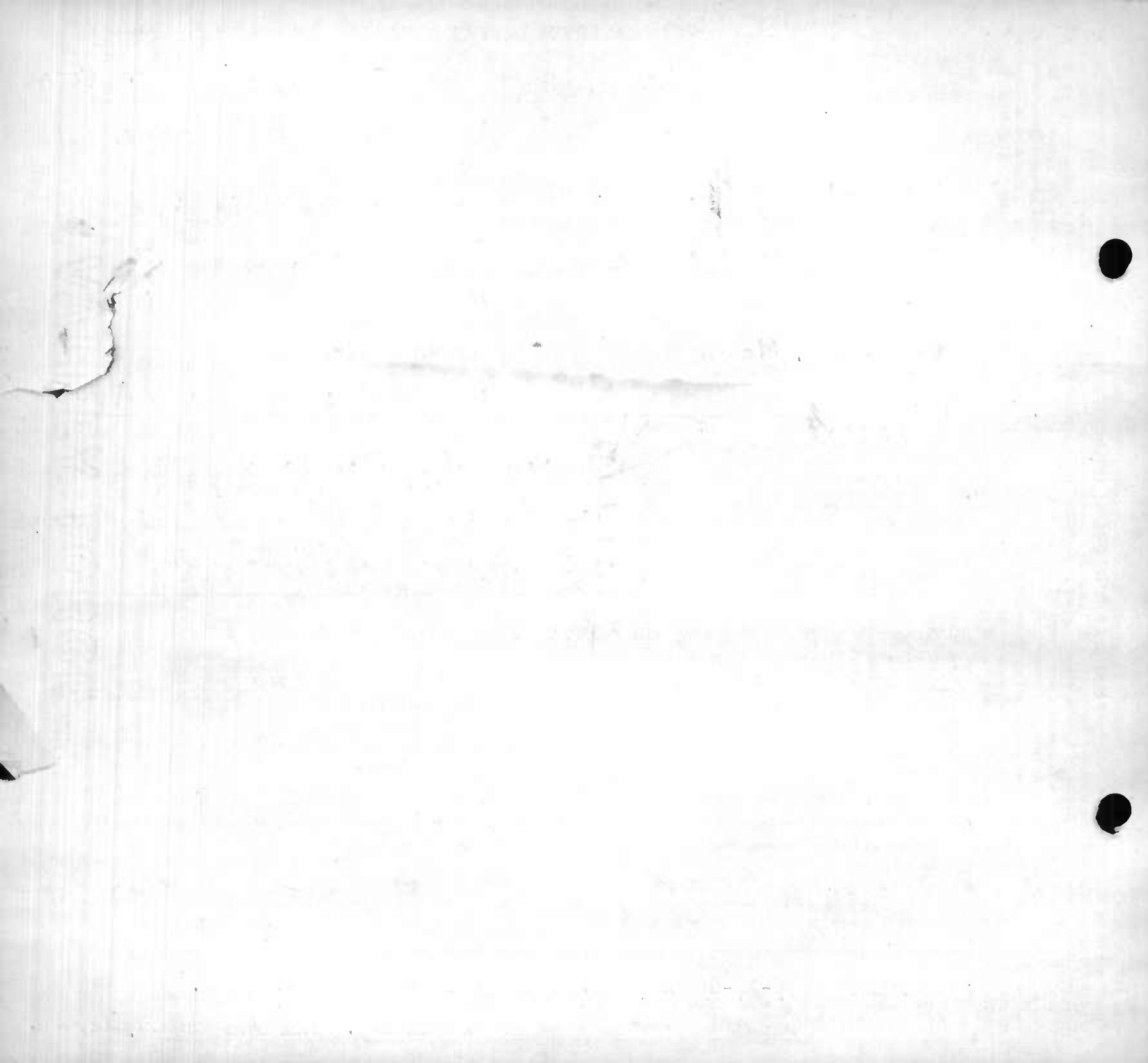
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9821 | |
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| BIRTH NO. | | 65 9821 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | <i>Elma Naomi Whiting</i> | | <i>Sept. 23, 1965</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Pine Ridge Nursing Home</i> | | A. STATE <i>Md.</i> | | B. COUNTY <i>27-05</i> | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | <i>Baltimore</i> | |
| | | D. STREET ADDRESS (If rural, give location) | | <i>6519 Glenoak Ave.</i> | |
| 5. SEX <i>female</i> | 6. RACE <i>white</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Divorced</i> | 8. DATE OF BIRTH <i>March 20, 1908</i> | 9. AGE (In years last birthday) <i>57</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Social Security</i> | | 11. BIRTHPLACE (State or foreign country) <i>Balto., Md.</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>George A. Frederick</i> | | 14. MOTHER'S MAIDEN NAME <i>Addie B. Lovett</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>213095005</i> | | 17. INFORMANT <i>Mrs. Edna M. Millett</i> | |
| 18. <i>170X I</i> | | CAUSE OF DEATH | | ADDRESS <i>Same</i> | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) <i>Carcinoma breast, right</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>19 Months</i> | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION <i>12-18-44</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Carcinoma breast</i> | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1938</i> to <i>9-23-65</i> 19 <i>19</i> that (I) (we) last saw the deceased alive on <i>9-23-65</i> 19 <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>E. W. Peake</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>9-24-65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>E. W. PEAKE</i> | | 23D. ADDRESS <i>11508 Harford Road Balto 14, Md.</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>9/27/65</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park Cemetery</i> | |
| 24D. LOCATION <i>Balto., Md.</i> | | 24E. DATE REC'D BY HEALTH DEPT. <i>SEP 24 1965</i> | | 24F. NAME OF REGISTRAR <i>Robert E. Taylor</i> | |
| 24G. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc</i> | | 24H. ADDRESS <i>Baltimore, Md.</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

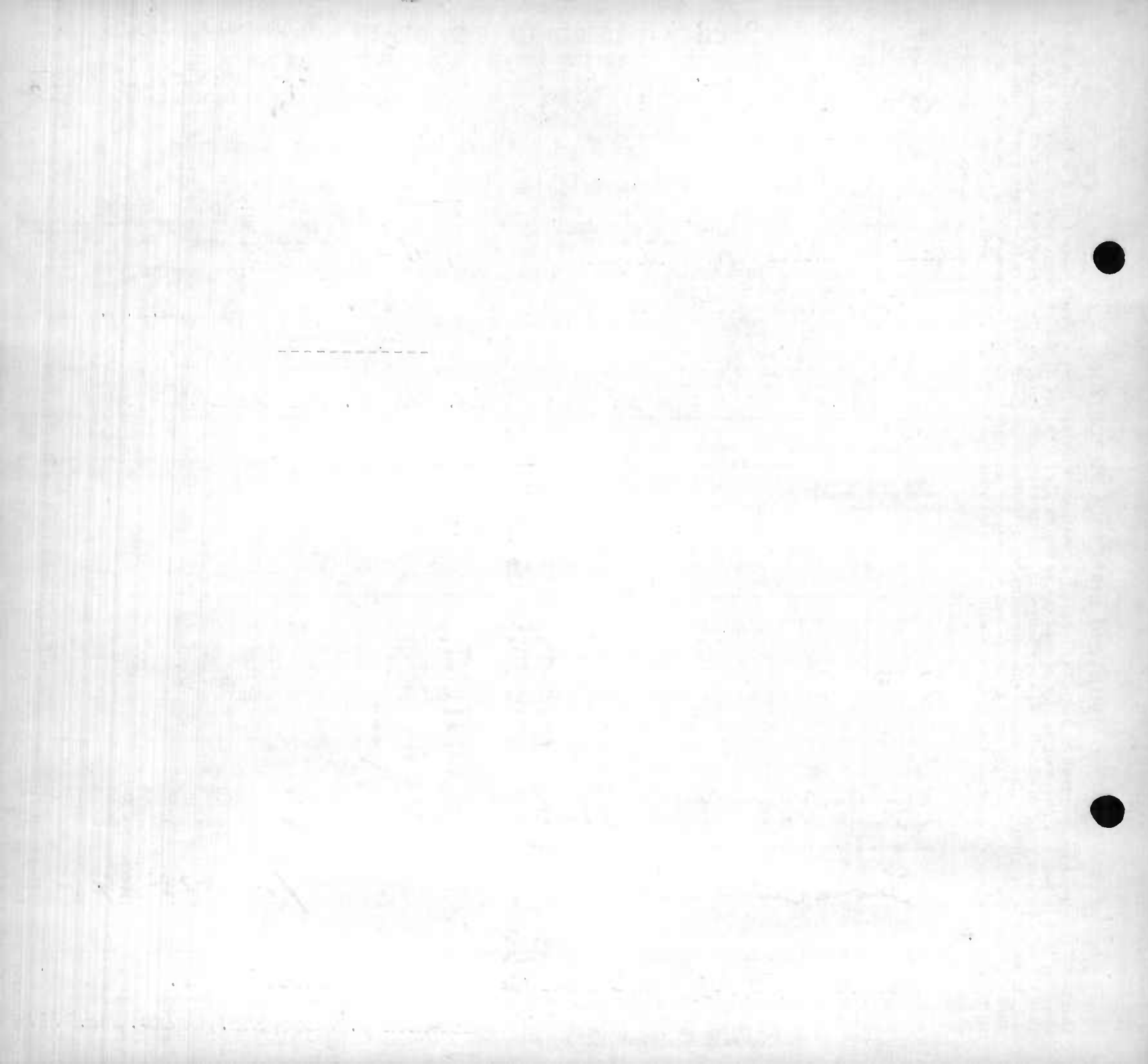
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65-2235165 9822 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9822 | |
| M.E. CASE NO. | | | 2. | | |
| 1. NAME OF DECEASED (Type or Print) <i>Vanessa S. Maule</i> | | | DATE AND HOUR OF DEATH <i>9/23/65 10:35 A.M.</i> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>UNIVERSITY HOSPITAL</i> | | | A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 27-01</i> | | |
| | | | D. STREET ADDRESS (If rural, give location) <i>2811 Clearview Ave</i> | | |
| 5. SEX <i>F</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>single</i> | 8. DATE OF BIRTH <i>9/6/65</i> | 9. AGE (In years last birthday) <i>17 days</i> | If Under 1 Yr. Months: Days: Hours: Min. <i>17</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 13. FATHER'S NAME <i>Raymond C. Maule</i> | | 14. MOTHER'S MAIDEN NAME <i>Linda Newell</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or service) <i>No</i> | | 16. SOCIAL SECURITY NO. | | ADDRESS <i>Parents 2811 Clearview Ave</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>754.51</i> | | | CAUSE OF DEATH (A) <i>Ventricular Fibrillation</i> DUE TO <i>Congenital heart disease during operation</i> DUE TO <i>1) Atrial Septal defect</i> <i>2) Ventricular Septal defect</i> <i>3) Transposition of great vessels</i> <i>4) Situs Inversus</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>5 min</i> <i>17 days</i> |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> | | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Congestive Heart Failure</i> | | |
| 19A. DATE OF OPERATION <i>3/9/23/65</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>transposition</i> | | 20A. AUTOPSY? (Yes or No) <i>YES</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9/1/65</i> to <i>9/23/65</i> , that (I) (we) last saw the deceased alive on <i>9/23/65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>B. Ann Ward</i> | | | | 23B. DATE SIGNED <i>9/23/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>B. Ann Ward</i> | | | | 23D. ADDRESS <i>M.D.</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i> | | 24B. DATE <i>9-24-65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i> | |
| | | | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 24 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc</i> | |
| | | | | ADDRESS <i>Baltimore, Md.</i> | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------|--------------------------------|
| 65 9823 | | CERTIFICATE OF DEATH | | 65 9823 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Mr. William C. Bryant | | 23 Sept. 1965 2:45 AM. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE Maryland | | B. COUNTY 27-44 | |
| Maryland General Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore | |
| | | D. STREET ADDRESS (If rural, give location) | | 5914 5915 Edna Ave. | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months Days |
| Male | White | Single | 9/14/28 | 37 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? | |
| Press man | | The Sun Papers | Baltimore | U.S.A. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | | |
| Vernon Bryant | | Marguerite Vollrath | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT. | | ADDRESS |
| Unknown | | 220 22 4938 | Mrs. Mary A. Prestianni, | | Same |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO | | | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) DUE TO | | | |
| II | | - None - | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 2 | | Yes | Yes | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | |
| 22. I certify that (X) (this hospital) attended the deceased from 30 August 1965 to 23 Sept. 1965, that (X) (we) lost saw the deceased alive on 23-Sep-1965 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| Thomas Carlton Culb | | | | 23-Sep- | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) | | |
| Burial | 9/27/65 | Baltimore National | Baltimore, Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| SEP 24 1965 | Robert E. Finken | Leonard J. Ruck, Inc., Balto., Md. | | 21214 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9824 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| | | | | LFE ANNIE MARIE | | September 23, 1965 7 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | | | A. STATE | | | |
| University Hospital | | | | Maryland | | | |
| 5. SEX | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| F | | | | Baltimore | | | |
| 6. RACE | | | | D. STREET ADDRESS (If rural, give location) | | | |
| N | | | | 1039 Argyle Ave | | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | |
| Married | | | | 9/7/1911 | | 54 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Housewife | | | | Glochester, VA. | | USA | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| UNKNOWN | | | | MARY E. Bradford | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | | | Medical Records | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | | 6 hrs | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 2 | | | | Yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 23 1965 to Sept 23 1965, that (I) (we) lost saw the deceased alive on Sept 23 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| Garry N. Rosenbaum | | | | | | 9/23/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| GARRY N. ROSENBAUM | | | | UNIVERSITY HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 9-27-65 | | Mt. Auburn | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| SEP 24 1965 | | R. B. E. Johnson | | Morton & Dett | | 1701 Laurens | |

FUNERAL DIRECTOR: IMPORTANT

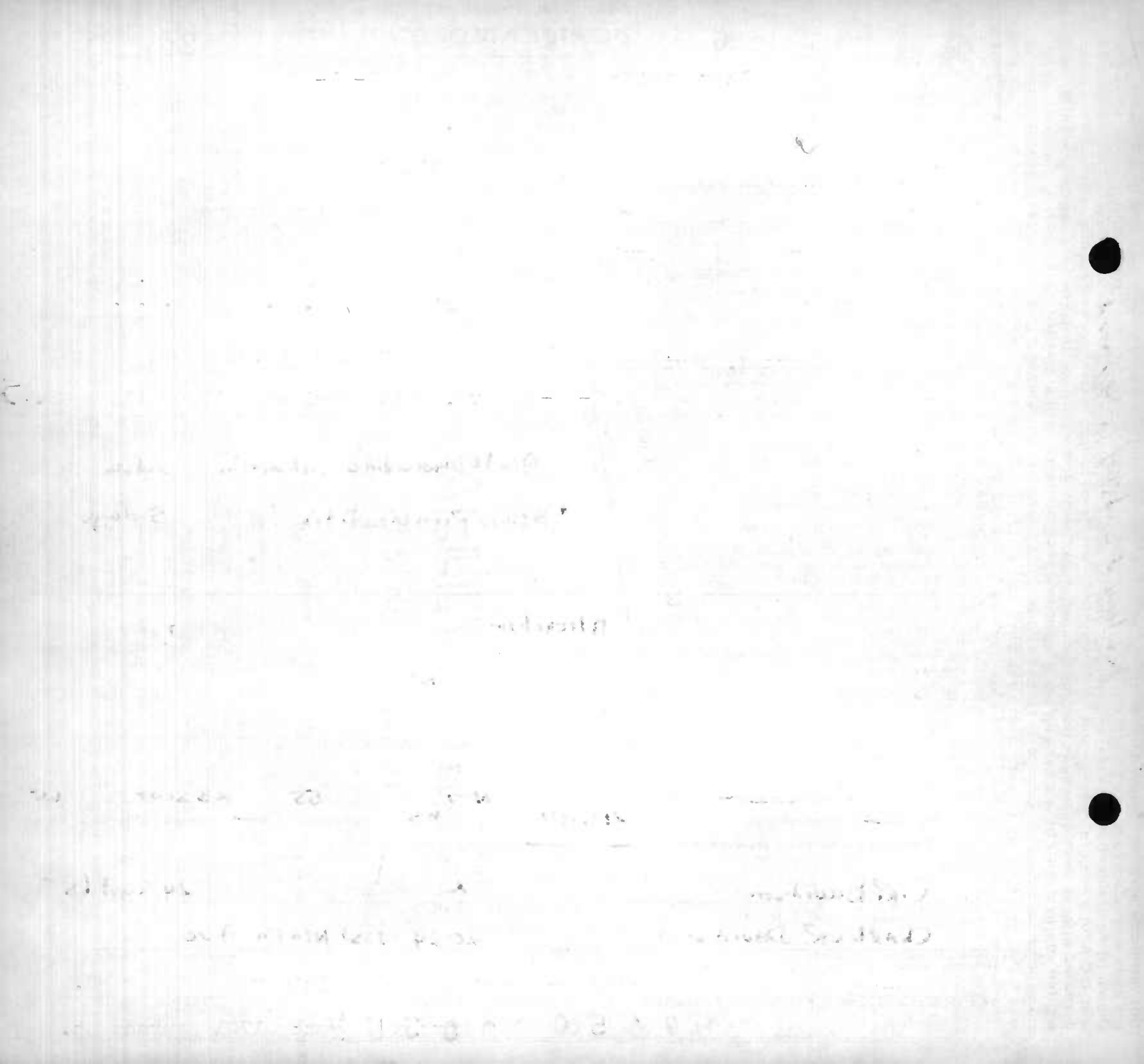
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9825 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------|-----------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 65 9825 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) LAWRENCE CHISHOLM | | 2. DATE AND HOUR OF DEATH Sept. 23, 1965 2:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital | | A. STATE Maryland B. COUNTY 8-05 | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN Baltimore (If outside city limits, write RURAL and give township) | | | |
| | | D. STREET ADDRESS 2027 Cliftwood Avenue (If rural, give location) | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 6-15-1903 | 9. AGE (In years last birthday) 62 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor | | 10B. KIND OF BUSINESS OR INDUSTRY worked for State | | 11. BIRTHPLACE (State or foreign country) Marlington, Virginia | |
| 13. FATHER'S NAME Robert Chisholm | | 14. MOTHER'S MAIDEN NAME Unknown | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 232-22-5377 | | 17. INFORMANT ADDRESS Miss Elizabeth Chisholm-2027 Cliftwood Ave. | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO | | | |
| | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9-23-65 19 9-23 to 9-23 19 65 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 9-23 19 65 and that in our (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Teodor R. Carangal</i> M.D. | | | | 23B. DATE SIGNED 9-23-1965 | |
| 23C. PHYSICIAN'S NAME (Type) Teodor R. Carangal | | | | 23D. ADDRESS St. Joseph's Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-27-65 | | 24C. NAME OF CEMETERY or CREMATORY Maplewood Cemetery | |
| 24D. LOCATION ELKINS, W. VA. | | 24E. LOCATION (City, town, or county) | | 24F. LOCATION (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 24 1965 | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR <i>Morton J. Dye</i> | |
| | | | | ADDRESS 1701 Laurens | |

Referred Subject to Approval
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

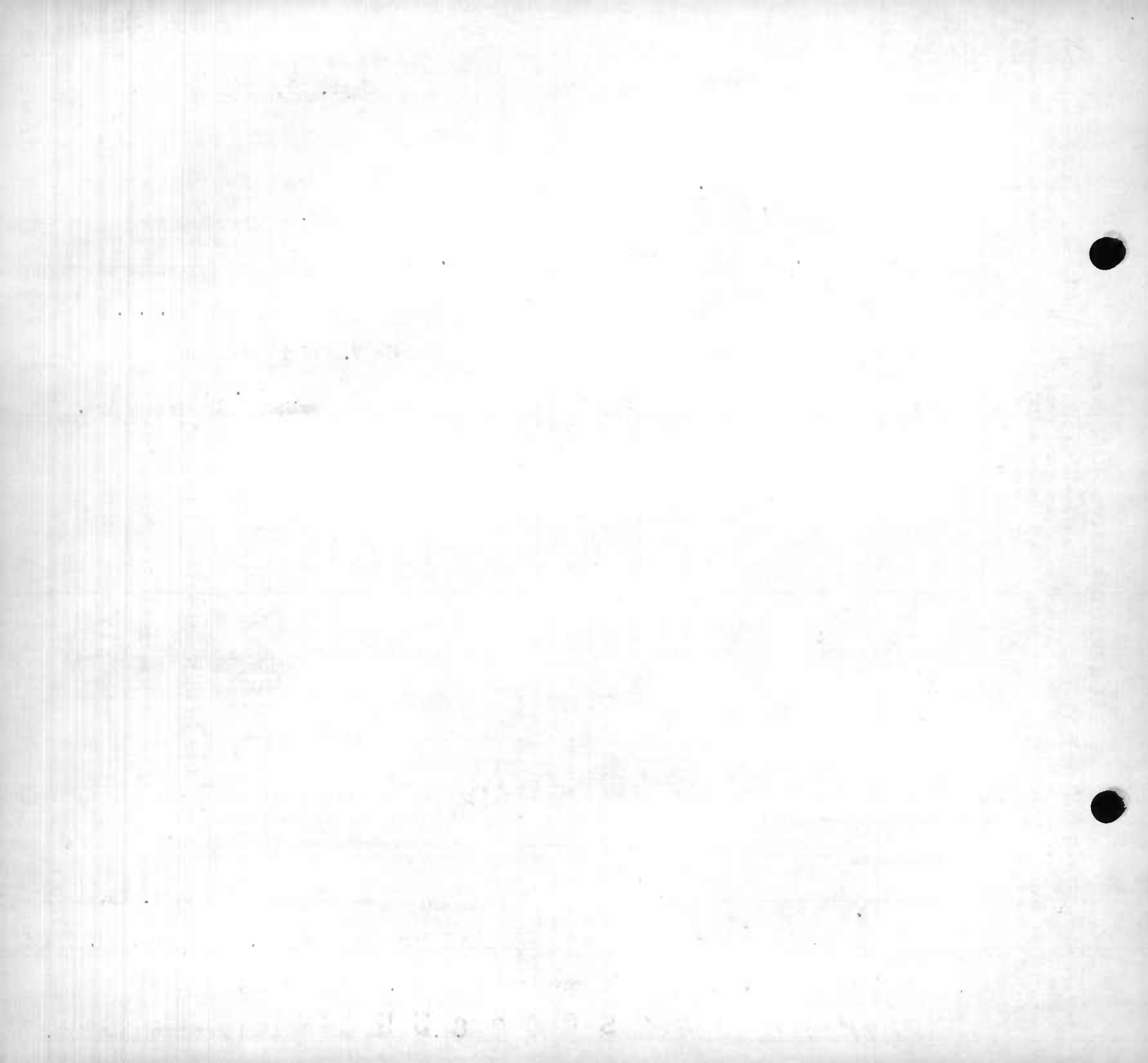
| | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|------------------------------------------------------------------------------------------|---------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 65 9826 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9826 | |
| M.E. CASE NO. 65 9826 | | CERTIFICATE OF DEATH | | Registered No. 65 9826 | |
| 1. NAME OF DECEASED (Type or Print) Walter Davidson | | 2. DATE AND HOUR OF DEATH 9-23-65 6 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3907 Parkview Avenue | | A. STATE Md. B. COUNTY Baltimore | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 3907 Park View Avenue | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 1-1-1925 | 9. AGE (in years last birthday) 40 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dentist | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Springdale, N. C. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Robert J. Davidson | | 14. MOTHER'S MAIDEN NAME Frances Wilson | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes | | 16. SOCIAL SECURITY NO. 245-18-2245 | | 17. INFORMANT Mrs. Edith Davidson | |
| 18. 322.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Alcoholism | | CAUSE OF DEATH (A) Acute myocardial infarction (B) Acute pancreatitis (C) | | INTERVAL BETWEEN ONSET AND DEATH sudden 5 days ? | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At Work Not White At Work | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (the hospital) attended the deceased from Nov 19 55 to 23 Sept 19 65, that (I) (we) last saw the deceased alive on 21 Sept 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE C.R. Davidson | | | | 23B. DATE SIGNED 24 Sept 65 | |
| 23C. PHYSICIAN'S NAME (Type) Charles R. Davidson | | | | 23D. ADDRESS M.D. 2034 West North Ave | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY Baltimore National | |
| 24D. LOCATION (City, town, or county) Baltimore | | 24E. STATE (State) Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 24 1965 | | 25B. NAME OF REGISTRAR Robert J. Davidson | | 25C. FUNERAL DIRECTOR Morton S. Dyett | |
| 25D. ADDRESS 1701 Laurens St. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

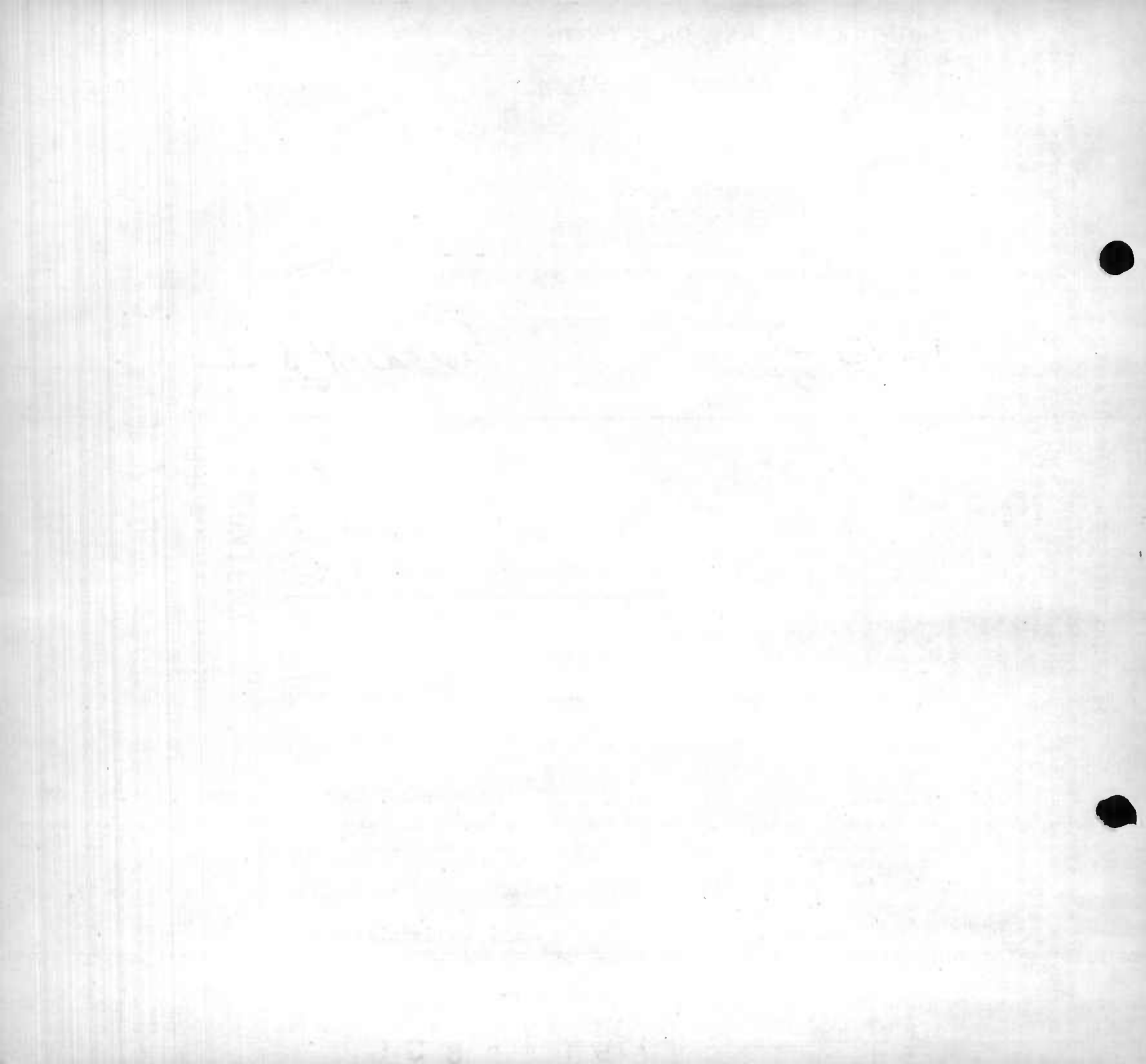
| Baltimore City Health Department | | | | Registered No. 65 9827 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|----------------------------------------------------------------|
| BIRTH NO. 65 9827 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) DOROTHY BERTHA WALKER | | | 2. DATE AND HOUR OF DEATH Sept. 21, 1965 | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3317 Dupont Ave. Baltimore, Maryland 21215 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-16 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3317 Dupont Ave. | | |
| 5. SEX Female | 6. RACE Cauc. | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Nov. 1, 1923 | 9. AGE (In years last birthday) 41 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME George Martin Hoffman | | | 14. MOTHER'S MAIDEN NAME Goldie V. Bright Hoffman | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 219 12 5634 | | 17. INFORMANT Jr. Addison Hall Walker 3317 Dupont Ave. | |
| 18. I 120X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH (A) DUE TO Carcinomatous (B) DUE TO Carcinoma of breast (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH 4 mo 5 mo |
| MEDICAL CERTIFICATION | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from June 1965 to Sept 1965 that (I) (we) last saw the deceased alive on Aug 29 1965 and that In (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death. | | | | | |
| 23A. SIGNATURE Ervin Sauber | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Sept. 23, 1965 |
| 23C. PHYSICIAN'S NAME (Type) Ervin Sauber | | | 23D. ADDRESS 6905 Park Heights Ave. Baltimore, Md. 21215 | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Sept. 24, 1965 | | 24C. NAME of CEMETERY or CREMATORY Baltimore National Cemo. | |
| 24D. LOCATION Catonsville, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. SEP 24 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR DE. LOWELL LEMMON | | | |
| 25D. ADDRESS 4611 Park Heights Ave. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

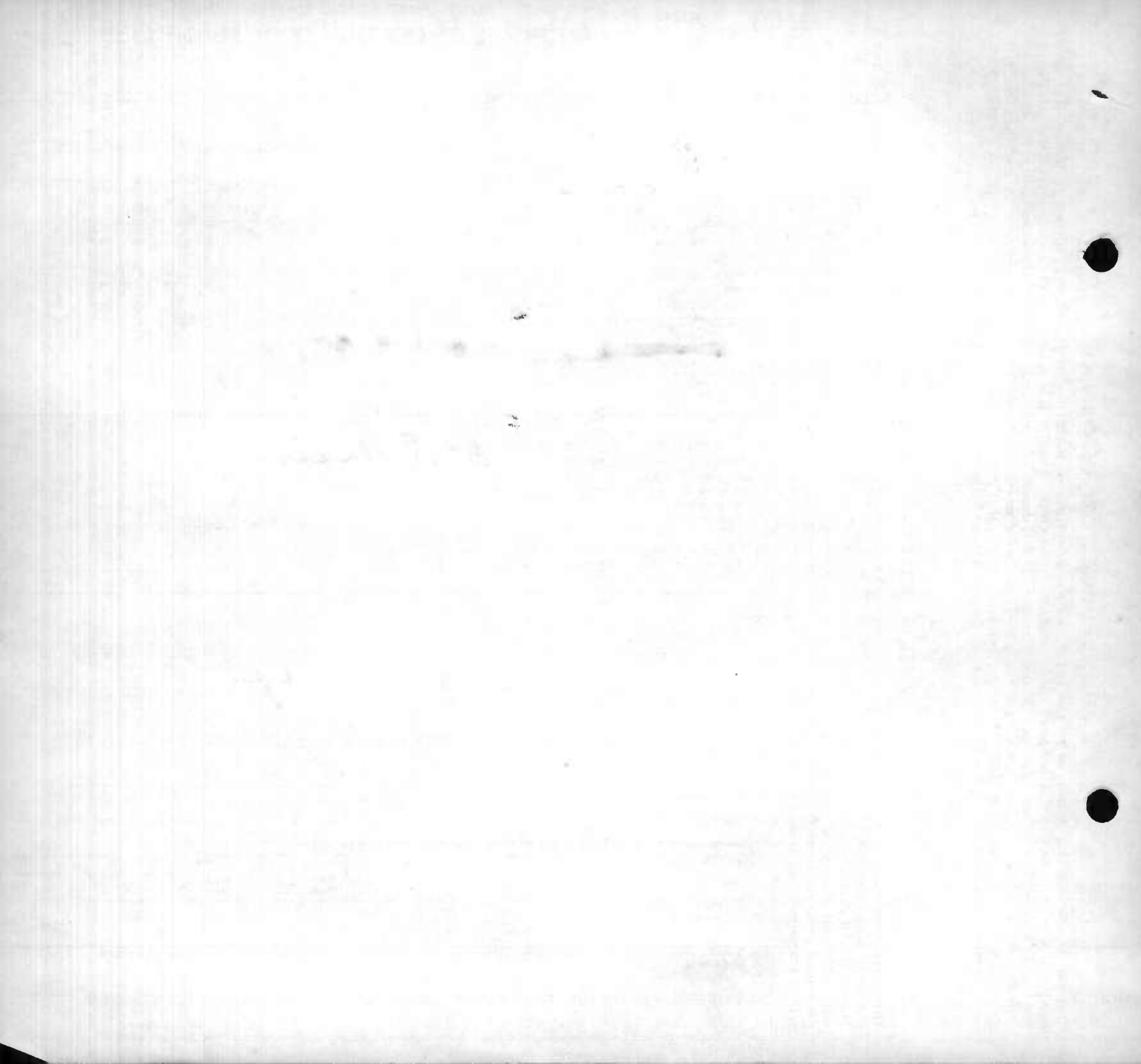
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>65 9828</u> | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|---------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. <u>65-24959</u> | | 65 9828 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Baby of Leatha McDowell</u> | | 2. DATE AND HOUR OF DEATH <u>September 17, 1965</u> <u>10:40</u> P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>19-01</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland</u> | | D. STREET ADDRESS (If rural, give location) <u>542 N. Carey Street</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>Negro</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH <u>9-17-65</u> | 9. AGE (In years last birthday) <u>6</u> <u>37</u> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>Charles</u> | | 14. MOTHER'S MAIDEN NAME <u>Leatha M. McManell</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. <u>75-3.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <u>Congenital absence of the skull bones</u> DUE TO (B) <u>Microcephalic</u> DUE TO (C) <u>Phocomelia</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | <u>Prematurity</u> | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>September 17, 1965</u> to <u>September 17, 1965</u> , that (I) (we) last saw the deceased alive on <u>September 17, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>M. Behrooz</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>September 22, 1965</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Behrooz</u> | | 23D. ADDRESS M.D. <u>1514 Division Street</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>SEP 23 1965</u> | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY <u>JOHNS HOPKINS MEDICAL SCHOOL</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 27 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Farley</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>MORTUARY SERVICE - BCHD</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

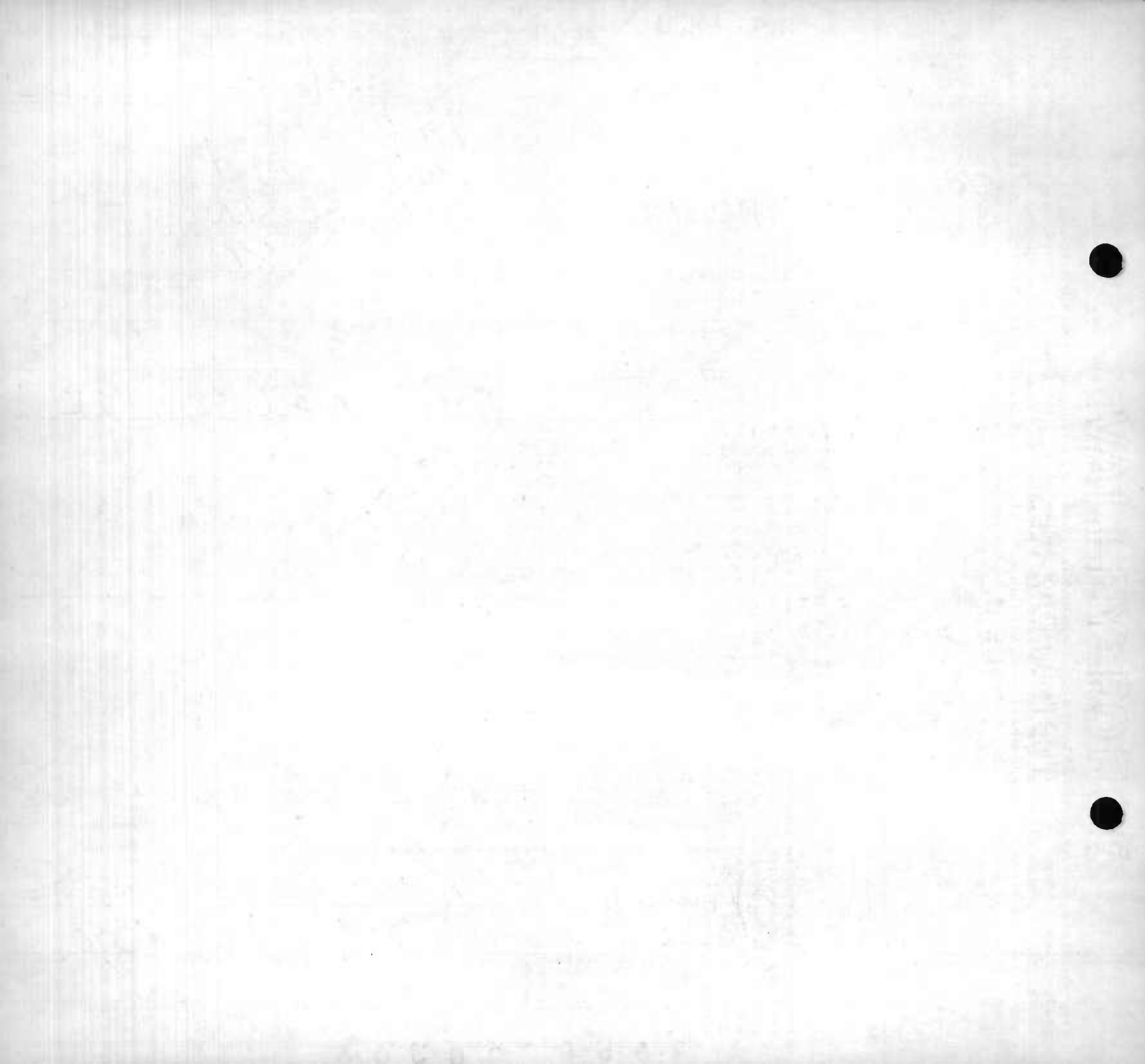
| | | | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|---------------------------------------|-------------------------------------------------|--|
| BIRTH NO. 65-2325565 | | 9829 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65-9829 | | 4 | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) Richard GENE Keller | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 2. DATE AND HOUR OF DEATH Sept 18, 1965 10:12 P.M. | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Md. GEN. Hosp. | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY AL C. CITY OR TOWN BALTO (If outside city limits, write RURAL and give township) #25-42-00 D. STREET ADDRESS (If rural, give location) 221 Meadow Rd | | | | |
| 5. SEX Male | | 6. RACE White | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH Sept 17, 1965 | | 9. AGE (In years lost birthday) 11 28 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) USA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Donald Franklin Keller | | | | | 14. MOTHER'S MAIDEN NAME DIANE Elsie Caldwell | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mother | | ADDRESS Same | |
| 18. 7-201 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Atelectasis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 17 1965 to Sept 18 1965 , that (I) (we) lost saw the deceased alive on Sept 18 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE J.W. Mann | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 21 Sept 65 | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | | 23D. ADDRESS M.D. JOHNS HOPKINS MEDICAL SCHOOL | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE SEP 23 1965 | | 24C. NAME OF CEMETERY OR CREMATORY JOHNS HOPKINS MEDICAL SCHOOL | | 24D. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR MORTUARY SERVICE - BOND | | ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|-------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 65 9830 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9830 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Ma Small</i> | | 2. DATE AND HOUR OF DEATH <i>Sept. 22. 65 1am</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>26-44</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balt MD</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>3025 WINDSOR AVE</i> | | D. STREET ADDRESS (If rural, give location) <i>14 N KRESSON ST</i> | | | |
| 5. SEX <i>7</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH <i>MAR 5, 1885</i> | 9. AGE (In years last birthday) <i>80</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>FRANK SMALL Son, WPK</i> | |
| 18. <i>422.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO <i>Cardio Vascular Disease</i> (B) DUE TO <i>Arterio Sclerosis ?</i> (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <i>2</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Sept 3</i> to <i>Sept 22</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>Sept 21</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>W R Johnson</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>9-22-65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>W R Johnson</i> | | 23D. ADDRESS <i>403 Md Art Bldg</i> | | M.D. | |
| 24A. BURIAL CREMATION, DATE OF REMOVAL (Specify) <i>SEP 22 1965</i> | | 24B. NAME OF CEMETERY OR CREMATORY <i>ANATOMY BOARD OF MARYLAND</i> | | 24C. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 27 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Farber</i> | | 25C. FUNERAL DIRECTOR <i>UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCRD</i> | |



BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

GWENDOLYN JOHNSON

2. DATE AND HOUR PRONOUNCED DEAD

Sept. 25, 1965

1:25 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1712 Greenmount Ave.

5. SEX

female

6. RACE

negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

JUNE 7, 42

9. AGE (In years
last birthday)

23

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

Baito. Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Harry Rice

14. MOTHER'S MAIDEN NAME

Nancy Tisdale

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown. If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

None

17. INFORMANT

ADDRESS

HARRY RICE - 1801 N. BROADWAY.

18. 353.3

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Epilepsy and fatty metamorphosis of the liver
DUE TO

(B) DUE TO

(C) DUE TO

II
ANTECEDENT CAUSESDISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/25/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-28-65

23C. NAME OF CEMETERY or CREMATORY

Arbutus Memorial

23D. LOCATION (City, town, or county) (State)

Arbutus (Baito Co.) Md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 27 1965

24B. NAME OF REGISTRAR

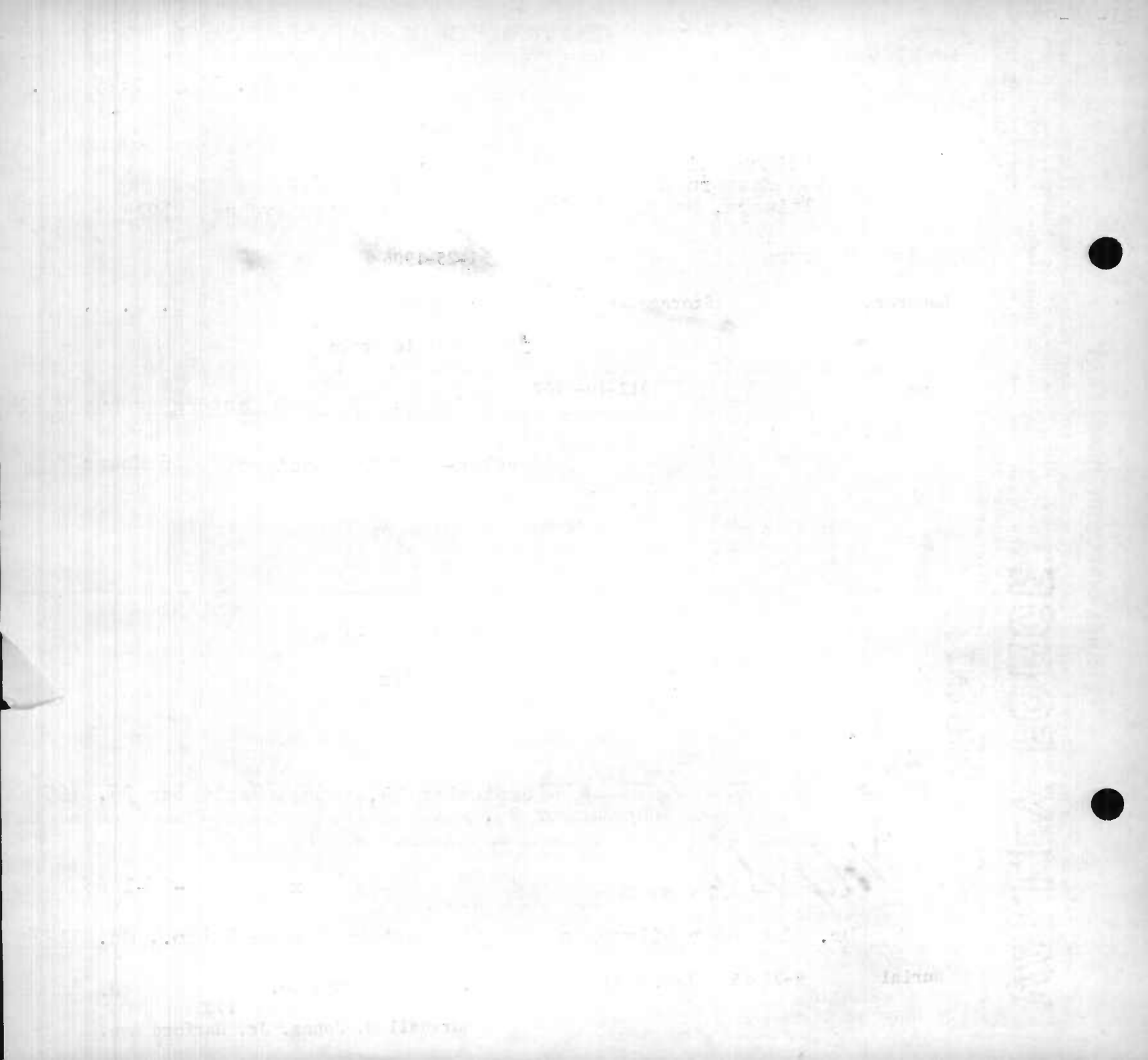
Robert E. Fairley, M.D.

24C. FUNERAL DIRECTOR

MARSHALL W. JONES JR. 1733 HARFORD AVE.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

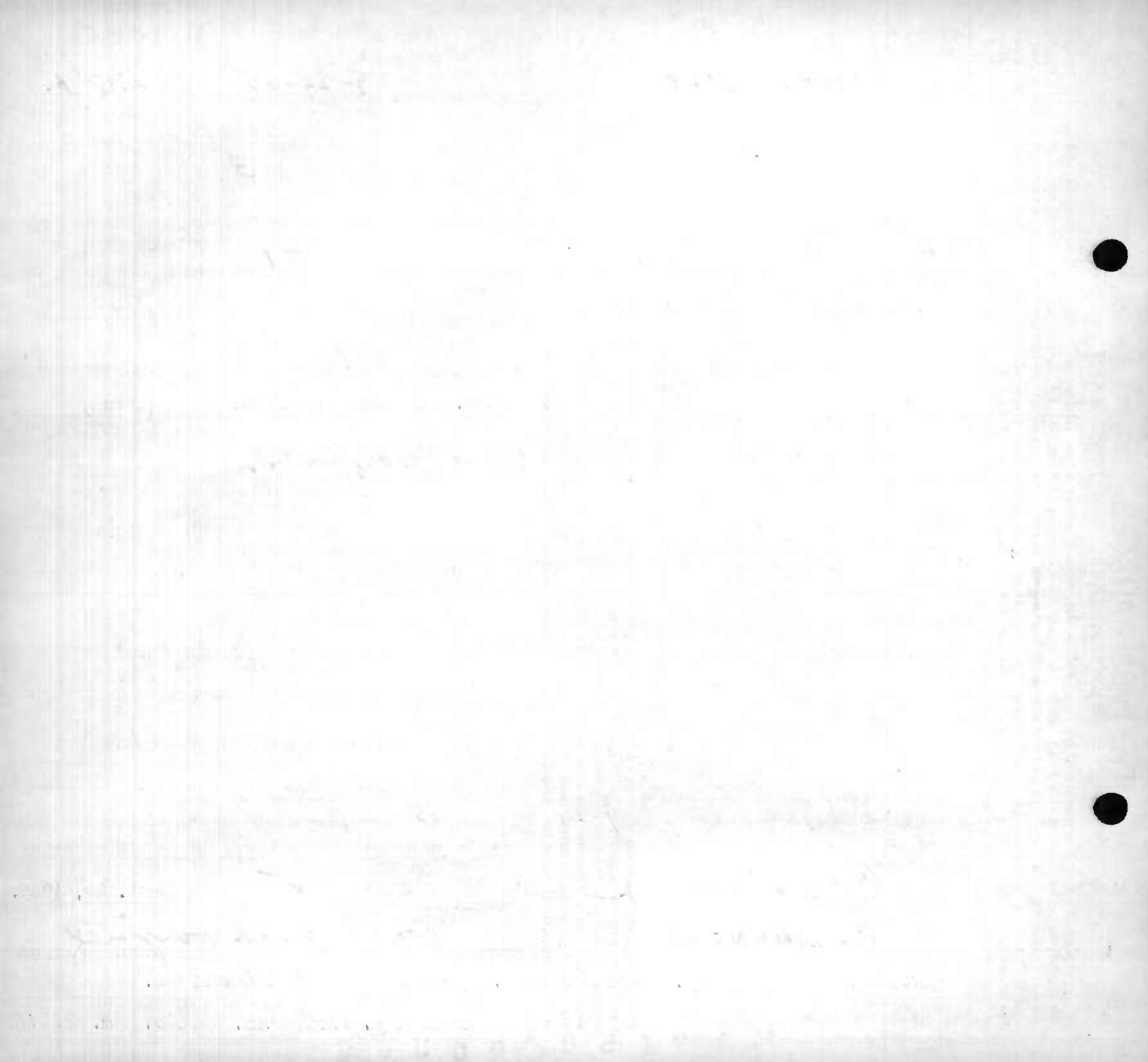
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9832 | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------------------------------|-------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. 326 65 9832 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) James Whitaker | | | | September 25, 1965 2:45 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | | A. STATE Maryland B. COUNTY 8-05 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1629 Cliftview Avenue 21213 | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Separated | 8. DATE OF BIRTH 1-25-1906 | 9. AGE (In years last birthday) 59 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY Storage | | 11. GRAFITY (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME ? | | | |
| 14. MOTHER'S MAIDEN NAME LAnnie Brown | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no at unknown) If yes, give war or dates of service) no | | | |
| 16. SOCIAL SECURITY NO. 212-10-5967 | | 17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue 21224 | | | |
| 18. 331X21199.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Metastatic Carcinoma | | | | CAUSE OF DEATH (A) Cerebro-Vascular Accident DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH 6 Hours | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from September 23, 1965 to September 25, 1965, that (I) (we) last saw the deceased alive on September 25, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Dr. Alexander Silverman | | | | 23B. DATE SIGNED 9-25-1965 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Alexander Silverman | | | | 23D. ADDRESS 4940 Eastern Avenue Balto., Md. 21224 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-29-65 | | 24C. NAME OF CEMETERY or CREMATORY Johnsville | |
| 24D. LOCATION Howard Co., Md. | | 24E. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | 24F. NAME OF REGISTRAR Robert E. Farley | |
| 24G. FUNERAL DIRECTOR Marshall W. Jones, Jr. | | 24H. ADDRESS 1735 Harford Ave. | | 24I. DATE 9-25-1965 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------|--|
| BIRTH NO. 65 9833 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9833 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MARY BICE | | 2. DATE AND HOUR OF DEATH 9-24-65 2:10 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY Maryland - Baltimore | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| Housewife | | Baltimore 34 5300 | | | |
| 15. SEX F | | 6. RACE W | | | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | | 8. DATE OF BIRTH 4/18/1914 | | 9. AGE (In years last birthday) 51 | |
| 10B. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Ross Shaffer | | 14. MOTHER'S MAIDEN NAME Elizabeth Weaver | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Mariann Rollison | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH Severe Malnutrition | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-17-1965 to 9-24-1965, that (I) (we) last saw the deceased alive on 9-24-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE C. C. Linantud, Jr. | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Sept. 24, 1965. | |
| 23C. PHYSICIAN'S NAME (Type) C. C. LINANTUD | | 23D. ADDRESS Bm Secours Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/27/65 | | 24C. NAME OF CEMETERY or CREMATORY Moreland Mem. Cemetery | |
| | | | | 24D. LOCATION (City, town, county) (State) Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md. 21214 | |



| BALTIMORE CITY HEALTH DEPARTMENT | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | Registered No. | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|
| BIRTH NO. | | 65 9834 | | | | 65 9834 | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR PRONOUNCED DEAD | | | |
| GORDON Lee SHEELER | | | | September 24, 1965 | | 9:30 A M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | | | A. STATE | | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | B. COUNTY | | | |
| Mercy Hospital | | | | Maryland | | | |
| | | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | | | |
| | | | | Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | 56A Oakgrove Drive | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | |
| Male | | White | | married | | 4-13-1897 | |
| 9. AGE (In years last birthday) | | 10. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 68 | | Lumber | | Maryland | | USA | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| William Sheeler | | | | Nancy Lee | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| yes | | | | 213011533 | | Liluan H. Sheeler same | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | (A) Congestive Heart Failure | | | |
| ANTECEDENT CAUSES | | | | (B) Arteriosclerotic and Hypertensive Cardiovascular Disease. | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | (C) | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 2 | | | | Yes | | Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE | | | | CHIEF MEDICAL EXAMINER | | DATE SIGNED | |
| EXAMINER'S NAME (Type) Charles S. Petty, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 9/24/65 | |
| ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME of CEMETERY or CREMATORY | | 23D. LOCATION (City, town, or county) (State) | |
| burial | | 9-27-65 | | Lorraine Park Cemetery | | Baltimore, Md. | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR ADDRESS | | | |
| SEP 27 1965 | | Robert E. Johnson | | Leonard J. Ruck Inc Baltimore, Md. | | | |

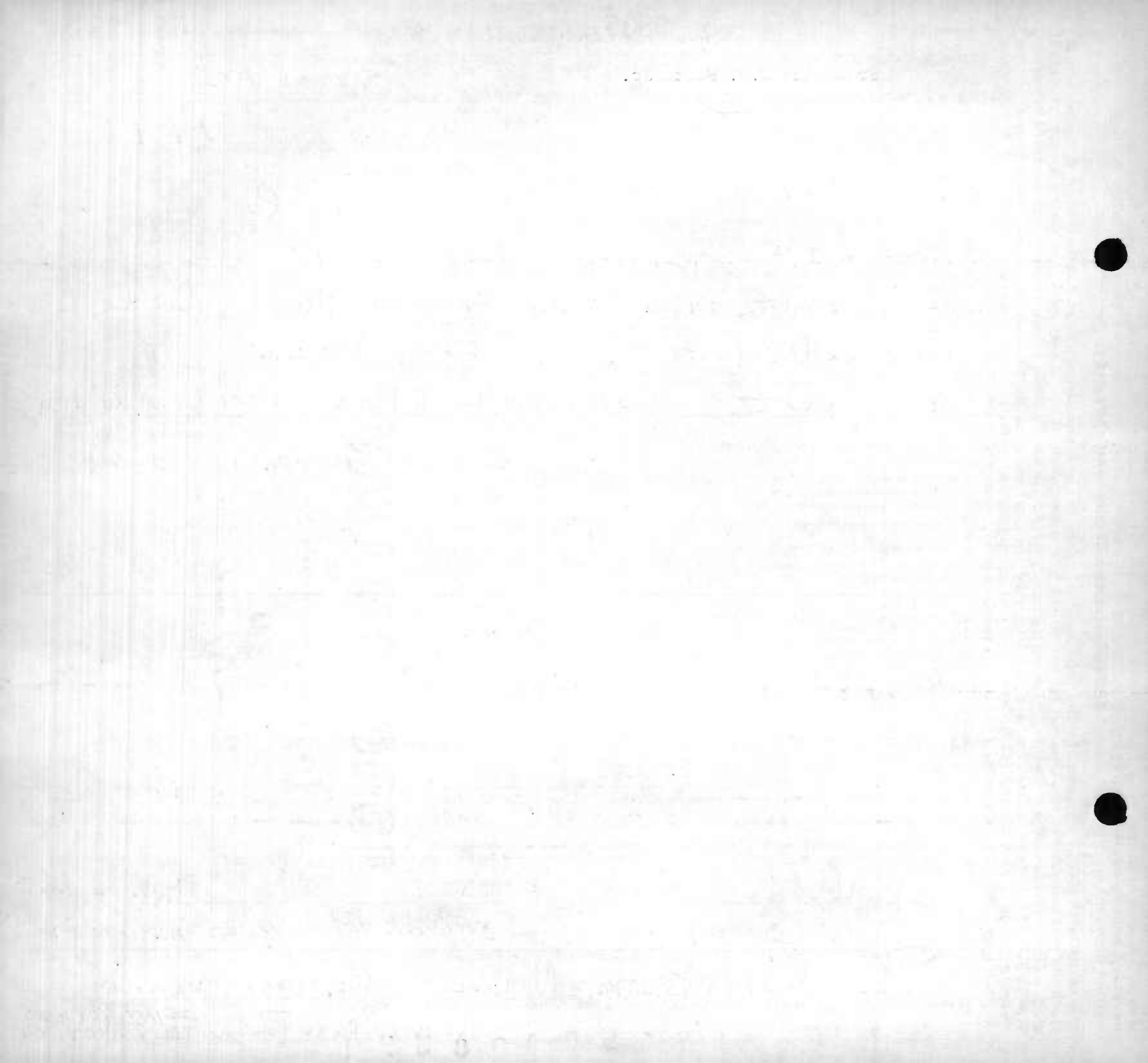
WALLACE B. GIBBS

Charles J. Gibbs

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

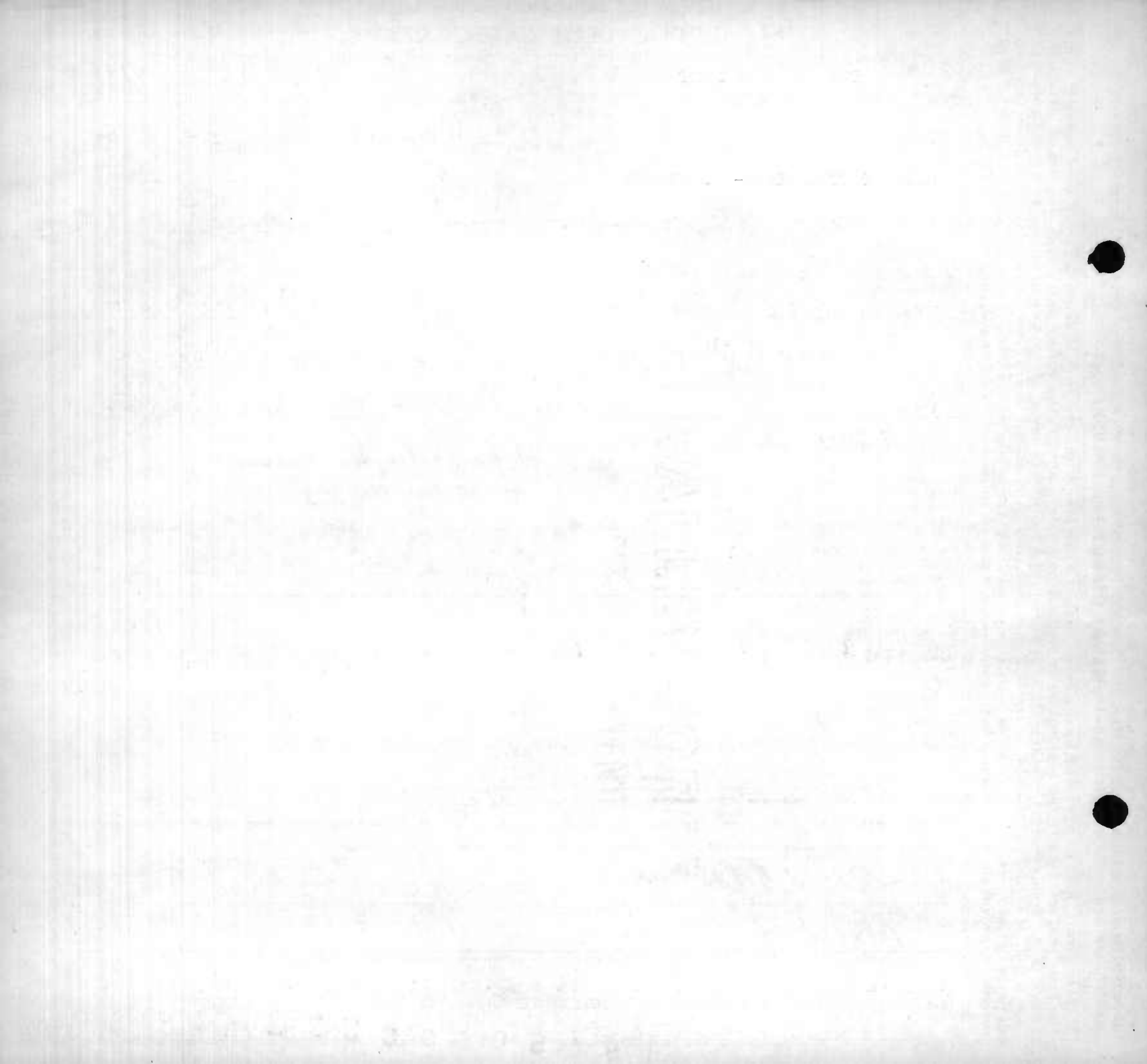
| BIRTH NO. 65 9835 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9835 | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------|------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|-----------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED (Type or Print) Fréderrick W.C. Foote Jr. | | | | 2. DATE AND HOUR OF DEATH Sept. 22, 1965 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1009 UPROR Rd | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 27-48 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1009 UPROR Rd | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH MAR. 25, 1920 | 9. AGE (In years lost birthday) 45 | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STATIONARY ENGINEER | | 10B. KIND OF BUSINESS OR INDUSTRY GYPSON COMPANY | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MD | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME FREDERICK W.C. FOOTE SR. | | | | 14. MOTHER'S MAIDEN NAME EMMA MCCOMAS | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II | | 16. SOCIAL SECURITY NO. 220-01-3427 | | 17. INFORMANT MRC. D. FOOTE - 1009 UPROR Rd 21212 | | | |
| 18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CORONARY THROMBOSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Emphysema | | | | INTERVAL BETWEEN ONSET AND DEATH Sudden. | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb. 17, 1965 to Sept. 21, 1965 , that (I) (we) last saw the deceased alive on Sept. 21, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Carl F. Benson, M.D. | | | | 23B. DATE SIGNED Sept. 24, 1965 | | | |
| 23C. PHYSICIAN'S NAME (Type) Carl F. Benson M.D. | | | | 23D. ADDRESS 5111 York Rd Balto. Md 21212 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-27-65 | | 24C. NAME OF CEMETERY or CREMATORY BALTIMORE NATIONAL | | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Wm. G. Brooks Towson | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
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| BIRTH NO. 65 9836 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9836 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) IDA MATTHEWS | | 2. DATE AND HOUR OF DEATH 9-22-65 1145 P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) HOUSE IN THE PINES- BELVEDERE | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 12-06 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2826 ST. PAUL ST. | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE | 8. DATE OF BIRTH Oct 18, 1883 | 9. AGE (In years last birthday) 81 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STENOGRAPHER | | 10B. KIND OF BUSINESS OR INDUSTRY Oil Co. | | 11. BIRTHPLACE (State or foreign country) PRINCE GEORGES CO. MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME EDWARD H. MATTHEWS | | | |
| 14. MOTHER'S MAIDEN NAME JULIA ROSABELLE WHEELER | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY NO. 219-28-1965 | | 17. INFORMANT MRS. JULIA BENSON Rt. 1 Box 72 COCKEYSVILLE, MARYLAND | | | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Arteriosclerotic cardio-vascular disease DUE TO (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 12-29-1965 to 9-22-1965, that (I) (we) last saw the deceased alive on 9-19-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Alfred G. Ossman Jr. | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9-23-65 | |
| 23C. PHYSICIAN'S NAME (Type) Alfred G. Ossman Jr. | | 23D. ADDRESS 1010 St Paul St. Balto 2 Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-25-65 | | 24C. NAME OF CEMETERY or CREMATORY FRIENDS BURIAL GROUND | |
| 24D. LOCATION (City, town, or county) (State) SPARKS, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Fajana | | 25C. FUNERAL DIRECTOR Wm Cook Brooks | | 25D. ADDRESS 1050 YORK RD TOWSON, MD. 21204 | |



BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 9837

1. NAME OF DECEASED
(Type or Print)

ALDONA LAYMAN

2. DATE AND HOUR PRONOUNCED DEAD

September 22, 1965 9:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

City Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore Dundalk 53-00

D. STREET ADDRESS (If rural, give location)

2747 Dungen Ct.

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Dec. 28-1914

9. AGE (In years
last birthday)

50

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Seamstress

10B. KIND OF BUSINESS OR INDUSTRY

Modern Tailor Mfg. Co.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Anthony T. Veliulis

14. MOTHER'S MAIDEN NAME

Ona Lukosiewicz

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

215-03-0019

17. INFORMANT

ADDRESS

Husband, Mr. Leonard Layman, #4, a, b, c, d.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Hypertensive cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

Bronchial asthma

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Sept. 22, 1965

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Sept. 27-1965 Holy Redeemer

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

Belair Rd. Balto. Md. 21213

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 27 1965

Robert E. Farley, M.D.

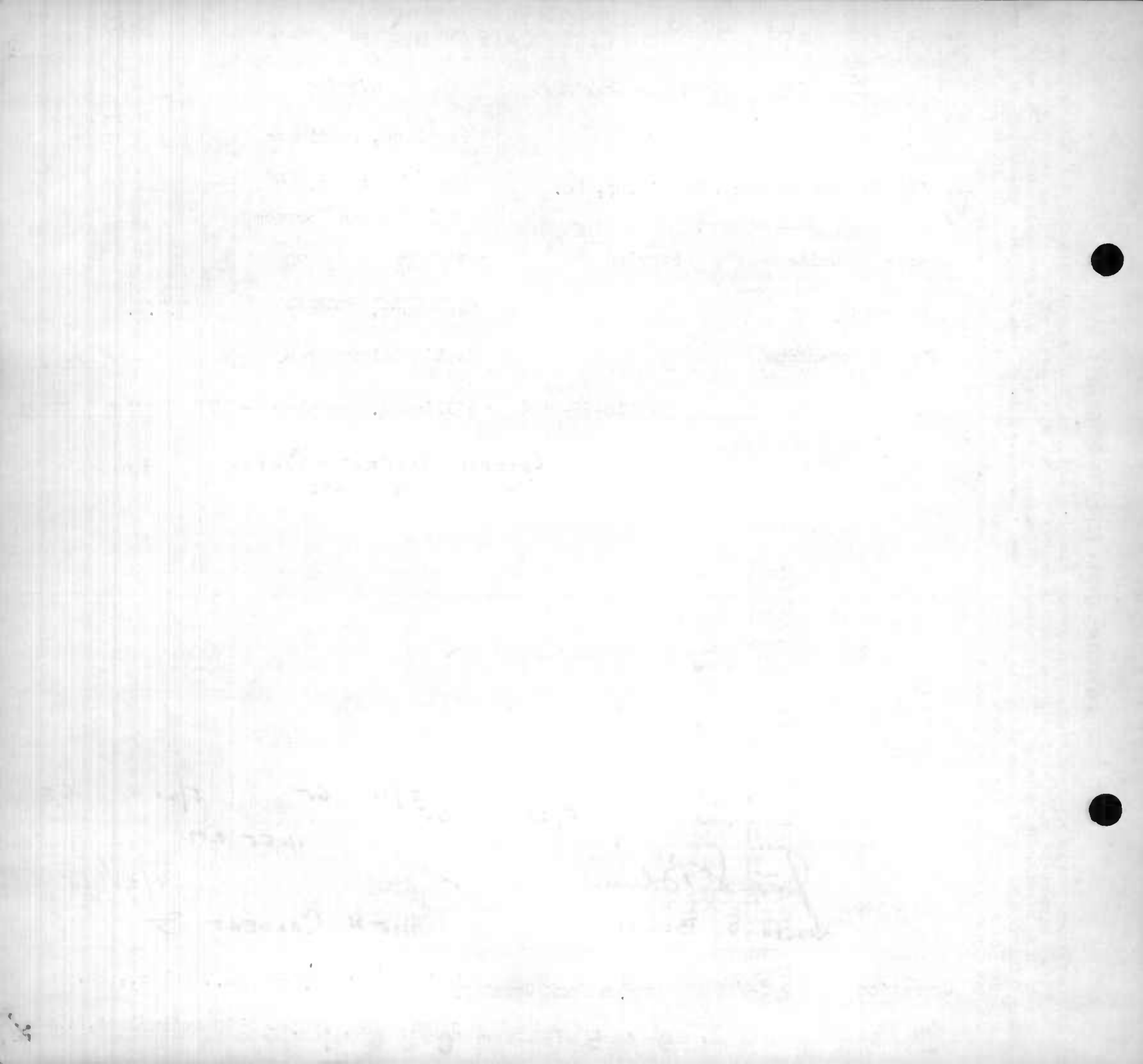
JOHN J. DUDA 7922 Wise Ave. Dundalk, Md. 22

VA
FAMILY
COMM
FON
G
E

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

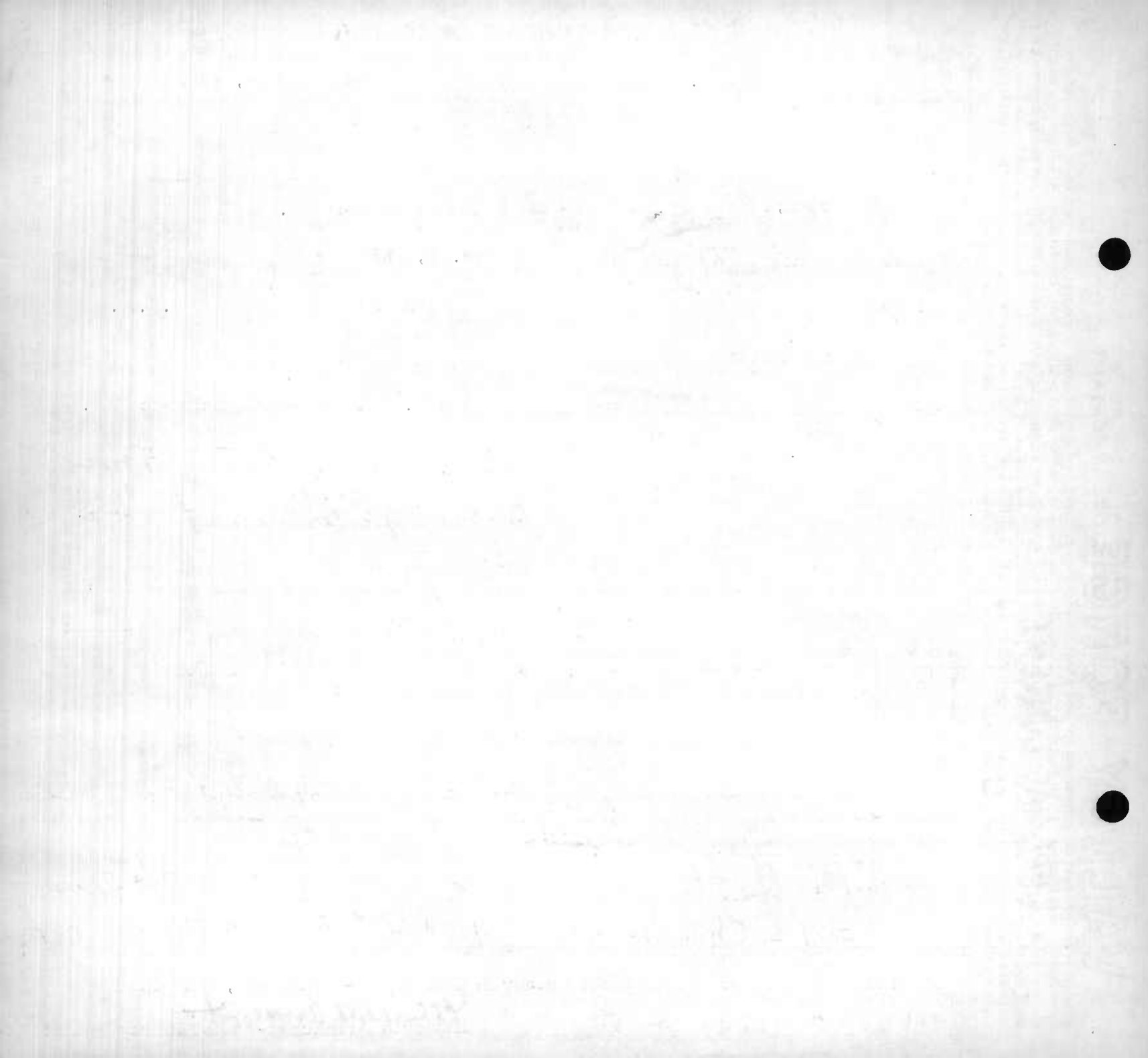
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|----------------------------------------------------------------------|--|
| 65 9838 | | | | | 65 9838 | | | | |
| BIRTH NO. | | | | | Registered No. | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) Else Rosenberg | | | | | 2. DATE AND HOUR OF DEATH 9/20/65 | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 2701 Chelsea Terrace, Baltimore, Md. | | | | | A. STATE Maryland, Baltimore | | | | |
| | | | | | B. COUNTY 15-38 | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore, Maryland | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 2701 Chelsea Terrace | | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH 3/30/1895 | 9. AGE (In years last birthday) 70 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Newenburg, Germany | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph Rosenbaum | | | | | 14. MOTHER'S MAIDEN NAME Sophia Geiershofer = GEIERSHOFER | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 218-09-2166 | | 17. INFORMANT ADDRESS William A. Rosenberg - 2701 Chelsea Terrace | | | |
| 18. CAUSE OF DEATH | | | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE | | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 3 mo. | | | | | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | | 21E. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 5/11 1965 to 5/21 1965 , that (I) (we) last saw the deceased alive on 5/21 1965 and that in (my) (our) opinion death occurred on the date 11.55 P.M. and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Joseph S. Blum | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED 9/23/65 | |
| 23C. PHYSICIAN'S NAME (Type) JOSEPH S. BLUM | | | | | 23D. ADDRESS 1115 N. CALVERT ST. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Cremation | | 24B. DATE 9/25/65 | | 24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery | | | 24D. LOCATION (City, town, or county) (State) Frederick Ave., Balto., Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | | 25B. NAME OF REGISTRAR Robert E. Taylor | | | 25C. FUNERAL DIRECTOR ADDRESS JACK LEWIS, INC. - 2100 Eutaw Place, Balto., Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|
| 65 9839 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9839 | |
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED | |
| | | | | Anna L. Lange | |
| 2. DATE AND HOUR OF DEATH | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| September 24, 1965 | | FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE Maryland | |
| | | Anderson; a Nursing Home | | B. COUNTY Baltimore | |
| 5. SEX | | 6. RACE | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| Female | | White | | Baltimore | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years lost birthday) | |
| Widowed | | Dec. 18, 1868 | | 96 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| At Home | | | | Baltimore | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| George Bauer | | Blessing | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | None | | Helen A. Letmate - 3603 Landbeck Rd. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | (A) Arterio Sclerotic Heart Disease | | 5 yrs. | |
| ANTECEDENT CAUSES | | (B) Cerebral Vascular Accident | | 4 days | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) Senility | | | |
| II | | Generalized arterio-sclerosis | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Dec. 5 - 19 39 to Sept. 24 19 65, that (I) last saw the deceased alive on Sept. 24 19 65 and that in my opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) | |
| Earl L. Chambers | | 9/25/65 | | Earl L. Chambers | |
| 23D. ADDRESS | | 23E. M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23F. ADDRESS | |
| 4108 Liberty Pl. - Balto - Md | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| BURIAL | | 9/28/65 | | Immanuel Lutheran Cemetery - Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| SEP 27 1965 | | Robert E. Farber, M.D. | | Ellsworth Armacost | |
| | | | | ADDRESS | |
| | | | | Ellsworth Armacost-4600 Liberty Heights Av. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|--|
| BIRTH NO. 65 9840 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9840 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | X | |
| 1. NAME OF DECEASED (Type or Print) | | KANE, MARGARET E. | | 2. DATE AND HOUR OF DEATH 9-22-65 7:20AM M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL BALTIMORE, MARYLAND | | MARYLAND | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) ELKRIDGE 6300 | |
| D. STREET ADDRESS (If rural, give location) RT 4 BOX 424 | | 5. SEX FEMALE | | 6. RACE WHITE | |
| 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | | 8. DATE OF BIRTH JAN. 1890 | | 9. AGE (In years lost birthday) 76 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Housework | | 10B. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME William Marks | | 14. MOTHER'S MAIDEN NAME Mary E. Smallwood | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN | | 16. SOCIAL SECURITY NO. unknown | | 17. INFORMANT ST. AGNES HOSPITAL RECORDS BALTO. 29, MD | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Meningitis - undetermined etiology (B) Relapsing anemia (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from 9-10-65 19 to 9-22 19 65, that (XX) (we) last saw the deceased alive on 9-22 19 65 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (and not) view the body after death. | | | | | |
| 23A. SIGNATURE [Signature] M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 9-22-65 | |
| 23C. PHYSICIAN'S NAME (Type) PEDRO P. PURCELL M.D. | | | | 23D. ADDRESS St. Agnes Hospital, Balto., Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE Burial Sept. 25/65 | | 24C. NAME OF CEMETERY or CREMATORY Meadowridge Mem. Park | |
| 24D. LOCATION (City, town, or county) | | 24E. LOCATION (City, town, or county) | | 24F. LOCATION (City, town, or county) | |
| 24G. LOCATION (City, town, or county) | | 24H. LOCATION (City, town, or county) | | 24I. LOCATION (City, town, or county) | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | 25B. NAME OF REGISTRAR [Signature] | | 25C. FUNERAL DIRECTOR R. V. Singleton, Glen Burnie, Md. | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9841 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9841 | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------------|--------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|-----------------------------------------------------------------------|-----------------------|
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) MAV WILSON | | | | 9-23-65 - 9:50 PM | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION SOUTH BALTO. GEN. HOSP - 1213 LIGHT ST. BALTO, MD. | | | | A. STATE Maryland B. COUNTY Anne Arundel | | | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN Pasadena (If outside city limits, write RURAL and give township) | | | |
| | | | | D. STREET ADDRESS (If rural, give location) Box 29 (Mountain Road) | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH May 26, 1904 | 9. AGE (In years last birthday) 61 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-Emp. | | 10B. KIND OF BUSINESS OR INDUSTRY Service Station | | 11. BIRTHPLACE (State or foreign country) Balto. Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME (Unknown) Klein | | | | 14. MOTHER'S MAIDEN NAME (Unknown) | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. 218-32-3890 | | 17. INFORMANT Mr. John Wilson, Jr. (son) | | ADDRESS Same As #2 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) | | CA, PANCREAS | | 5 mos. | | | |
| ANTECEDENT CAUSES | | (A) DUE TO | | (B) DUE TO | | (C) DUE TO | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CU | | | | | | | |
| 19A. DATE OF OPERATION 9-23-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED JAUNDICE | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-13-65 19 to 9-23-65 19, that (I) (we) last saw the deceased alive on 9-23-65 19, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Narciso A. De Borja M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-24-65 | |
| 23C. PHYSICIAN'S NAME (Type) NARCISO A. De Borja, M.D. | | | | 23D. ADDRESS SOUTH BALTO. GEN. HOSP - 1213 LIGHT ST. BALTO, MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Sept. 27/65 | | 24C. NAME OF CEMETERY or CREMATORY Glen Haven Mem. Park | | 24D. LOCATION (City, town, or county) (State) Glen Burnie, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | 25B. NAME OF REGISTRAR Robert E. Jackson | | 25C. FUNERAL DIRECTOR R. V. Singleton | | ADDRESS Glen Burnie, Md. | |

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1513 LIGHT ST. BALTIMORE, MD.

F W WIDOW

GA, PAUCREAS

D-33-02 JANUICE NO

D-33-02

Barrens Station

1513 LIGHT ST. BALTIMORE, MD.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | Registered No. | |
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| 65 9842 | | | | | | 15 9842 | |
| M.E. CASE NO. | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR PRONOUNCED DEAD | | | |
| STANLEY CAPLAN | | | | September 22, 1965 2:05 A.M. | | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | | A. STATE B. COUNTY | | | |
| Sinai Hospital | | | | Maryland | | | |
| | | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | | | |
| | | | | Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | 6907 Dorsett Avenue place | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. IF Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. | | |
| male | white | MARRIED | 9/15/1932 | 33 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| SALESMAN | | LAUNDRY EQUIPMENT | | BALTIMORE, MARYLAND | | USA | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| WILLIAM CAPLAN | | | | KATE GOLDMAN | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| YES | | | | MRS. ANITA CAPLAN 6907 DORSET PLACE | | | |
| 18. CAUSE OF DEATH | | | | | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | | | | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | | | |
| (A) Arteriosclerotic cardiovascular disease DUE TO | | | | | | | |
| (B) DUE TO | | | | | | | |
| (C) DUE TO | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | Yes | | Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) | | | | DATE SIGNED | | | |
| Rudiger Breitenecker, M.D. | | | | September 22, 1965 | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME OF CEMETERY or CREMATORY | | 23D. LOCATION (City, town, or county) (State) | |
| BURIAL | | 9/23/65 | | BETH TFILOH | | BALTIMORE, MARYLAND | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR | | ADDRESS | |
| SEP 27 1965 | | Robert E. Johnson | | SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | | | |

911211332

UNITED

BALTIMORE, MARYLAND

LABORATORY EQUIPMENT

SALES

KATE BOGGS

WILLIAM GAY

THE WITIA GAYSON BOAT COAST LINE

NEW

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12

BALTIMORE, MARYLAND

BETH TETON

911211332

THE WITIA GAYSON BOAT COAST LINE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9843 | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 65 9843 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Long, Luba</i> | | 2. DATE AND HOUR OF DEATH <i>9/21/65 2:29 PM M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>211</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Sinai Hospital of Balto</i> | | D. STREET ADDRESS (If rural, give location) <i>Levinale Nursing home</i> | | | |
| 5. SEX <i>FEMALE</i> | 6. RACE <i>WHITE</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i> | 8. DATE OF BIRTH | 9. AGE (in years) <i>42</i> | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i> | | 11. BIRTH PLACE (State, foreign country) <i>Kobryn, GERMANY</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 13. FATHER'S NAME <i>JACOB RYMLAND</i> | | 14. MOTHER'S MAIDEN NAME <i>HANNAH POROSOFFSKY</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces (If yes, give war or dates of service) <i>NO</i> | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>MR. MURRAY J. RYMLAND 7121 PARK HEIGHT AVE</i> | |
| 18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>Myocardial Infarction</i> | | CAUSE OF DEATH (A) DUE TO <i>ASCVD</i> (B) DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH <i>days</i> <i>years</i> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Multiple Sclerosis</i> | | <i>15 years</i> | |
| 19A. DATE OF OPERATION <i>2</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>No</i> | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9/20/65</i> 19 to <i>9/21/65</i> 19, that (I) (we) last saw the deceased alive on <i>9/21/65</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Harry Tabor</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>9/21/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>HARRY TABOR</i> | | 23D. ADDRESS <i>SINAI HOSPITAL</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>9/23/65</i> | | 24C. NAME of CEMETERY or CREMATORY <i>HAR SINAI</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>BALTIMORE MARYLAND</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 27 1965</i> | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Fairbank</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD</i> | | | |

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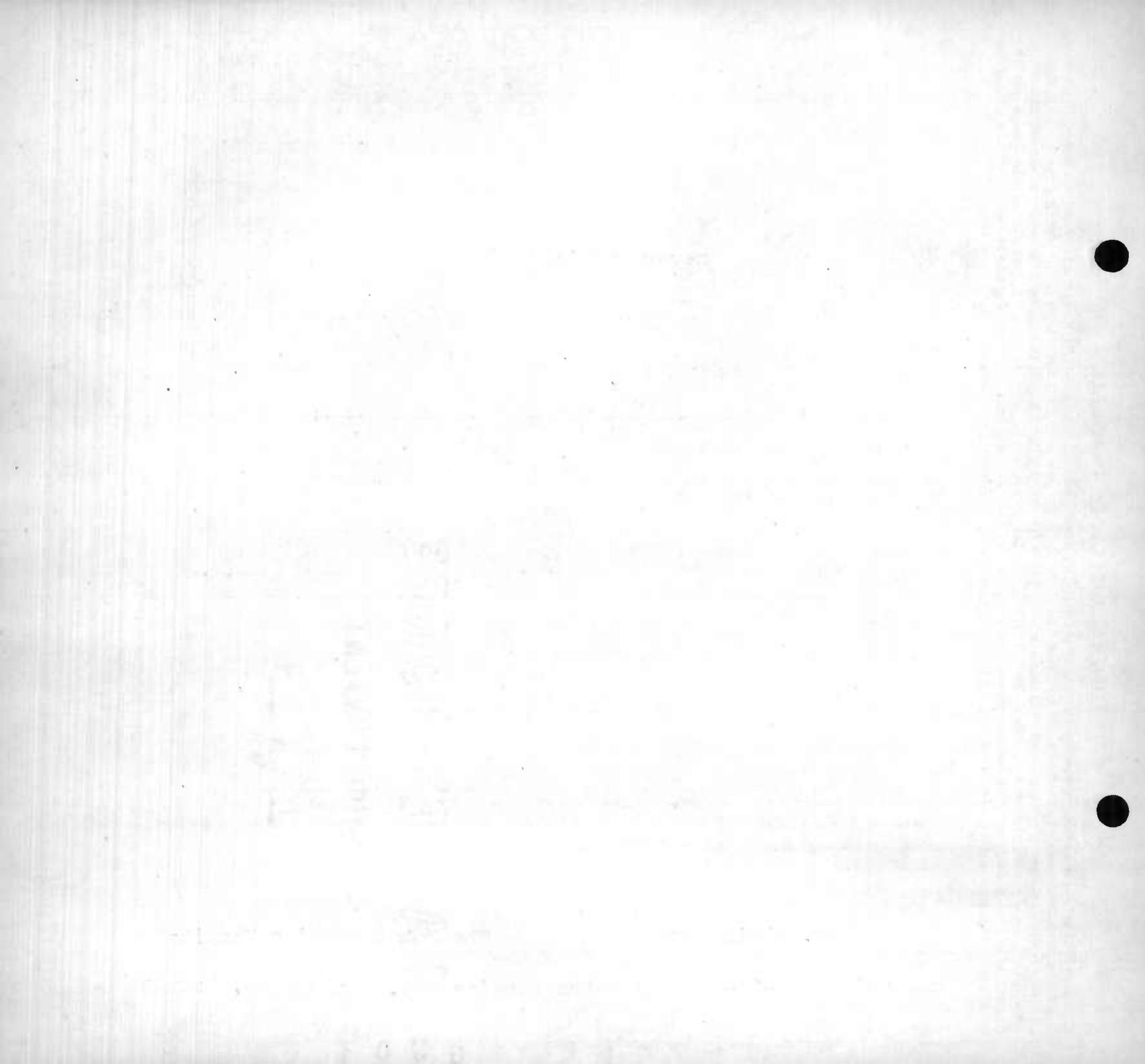
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

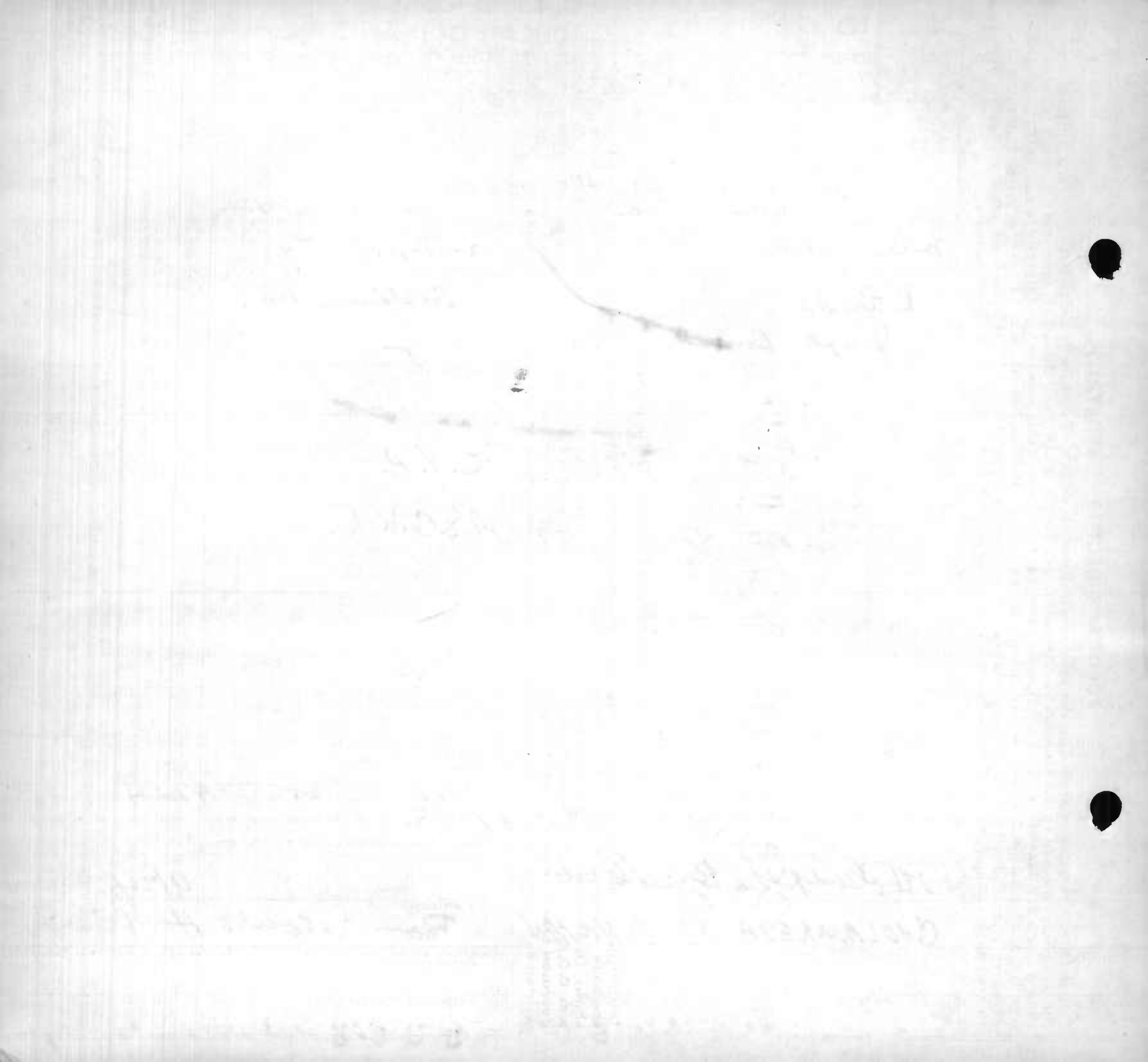
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| BIRTH NO. 65-24410 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9844 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | 1173328 | |
| 1. NAME OF DECEASED (Type or Print) QUEEN, Baby boy of | | ELIZABETH | | 2. DATE AND HOUR OF DEATH 9/24/65 6:15 a.m. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Maryland | | D. STREET ADDRESS (If rural, give location) Annapolis 52-10 | |
| 5. SEX Male | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) never married | |
| 8. DATE OF BIRTH 9-24-65 | | 9. AGE (In years last birthday) New Born | | 10. UNDER 1 Yr. Months Days 15 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME TURNER, ANDREW | | 14. MOTHER'S MAIDEN NAME ELIZABETH, QUEEN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS 37 Calvert St. Annapolis, Md | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) Priming Apnea | | INTERVAL BETWEEN ONSET AND DEATH 15 minutes | |
| ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.) | | (B) DUE TO | | (C) DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 6:00 am 9/24 19 65 to 6:15 am 9/24 19 65, that (I) (we) last saw the deceased alive on 9/24 19 65 and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Dr. Elwin Berger | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9/24/65 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. Elwin Berger | | 23D. ADDRESS The Johns Hopkins Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) cremation | | 24B. DATE 9-24-65 | | 24C. NAME of CEMETERY or CREMATORY The Johns Hopkins Hos. Baltimore, Maryland | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | 25B. NAME OF REGISTRAR Robert E. Falek | |
| 25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL | | ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|----------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------|--------------------------------------------------------|
| 65 9845 | | BURES | | 65 9845 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| | | Mr. John J Bures | | 9/24/65 5:30 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | 2938 E. Monument St. | | B. COUNTY | |
| Bon Secours Hospital | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | 7-01 | |
| 2025 West Fayette St | | D. STREET ADDRESS (If rural, give location) | | Baltimore Md. | |
| Baltimore Md | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| Male | White | Married | 2-19-1887 | 78 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Retired | | Railroad | | Baltimore Md. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| John Joseph Bures | | Levy | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | 705-10-9772 | | Mary Bures - 2938 E Monument St | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 422.1 I | | C.V.A. | | 14 days | |
| ANTECEDENT CAUSES | | (A) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | A.S.C.V.D. | |
| | | (C) | | | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY (Yes or No) | |
| 0 | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from | | 9/1/65 | | 19 65 to 9/24/19 65 | |
| that (I) (we) last saw the deceased alive on | | 9/24/19 65 | | and that in (my) (our) opinion death occurred on the date | |
| and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| Gholam Reza Pezeshtkian M.D. | | 9/24/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| GHOLAM REZA PEZESHKIAN M.D. | | Bon Secours Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 9/28/65 | | H. H. Reade Memorial Cemetery | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| SEP 27 1965 | | Robert E. Taylor | | Fidelity Co. 3019 Monument St | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY DEPARTMENT OF HEALTH | | | | Registered No. 65 9846 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------|--|
| BIRTH NO. | | 65 9846 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED <i>Kremel, Joseph Andrew KREMEL</i> | | 2. DATE AND HOUR OF DEATH <i>9/23/65 3:15 P. M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>Montebello State Hospital</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore 5300</i> D. STREET ADDRESS (If rural, give location) <i>6907 Linden Ave. Overlea.</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | 5. SEX <i>Male</i> | | 6. RACE <i>White</i> | |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>WIDOWED</i> | | 8. DATE OF BIRTH <i>2/13/1884</i> | | 9. AGE (In years last birthday) <i>81</i> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Steel worker</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>BETH. STEEL</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>USA.</i> | | 13. FATHER'S NAME <i>Joseph Kremel</i> | | 14. MOTHER'S MAIDEN NAME <i>Frances Kremel</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>213-07-5487A</i> | | 17. INFORMANT <i>Hospital Records</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Carcinoma of Prostate c metastases</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>Some years</i> | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>9/23/65</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>7/8/65</i> to <i>9/23/65</i> that (I) (we) last saw the deceased alive on <i>9/23/65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Daniel G. Lai</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>9/23/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>Daniel G. Lai</i> | | 23D. ADDRESS M.D. <i>2201 Conynne Drive, Baltimore, Md. 21218</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>9/27/65</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>HOLY REDEEMER CEM</i> | |
| 24D. LOCATION <i>BALTO. MARYLAND.</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 27 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Farley</i> | |
| 25C. FUNERAL DIRECTOR <i>THE DIPPEL BROTHERS INC</i> | | 25D. ADDRESS <i>7110 BELAIR RD. 21206</i> | | | |

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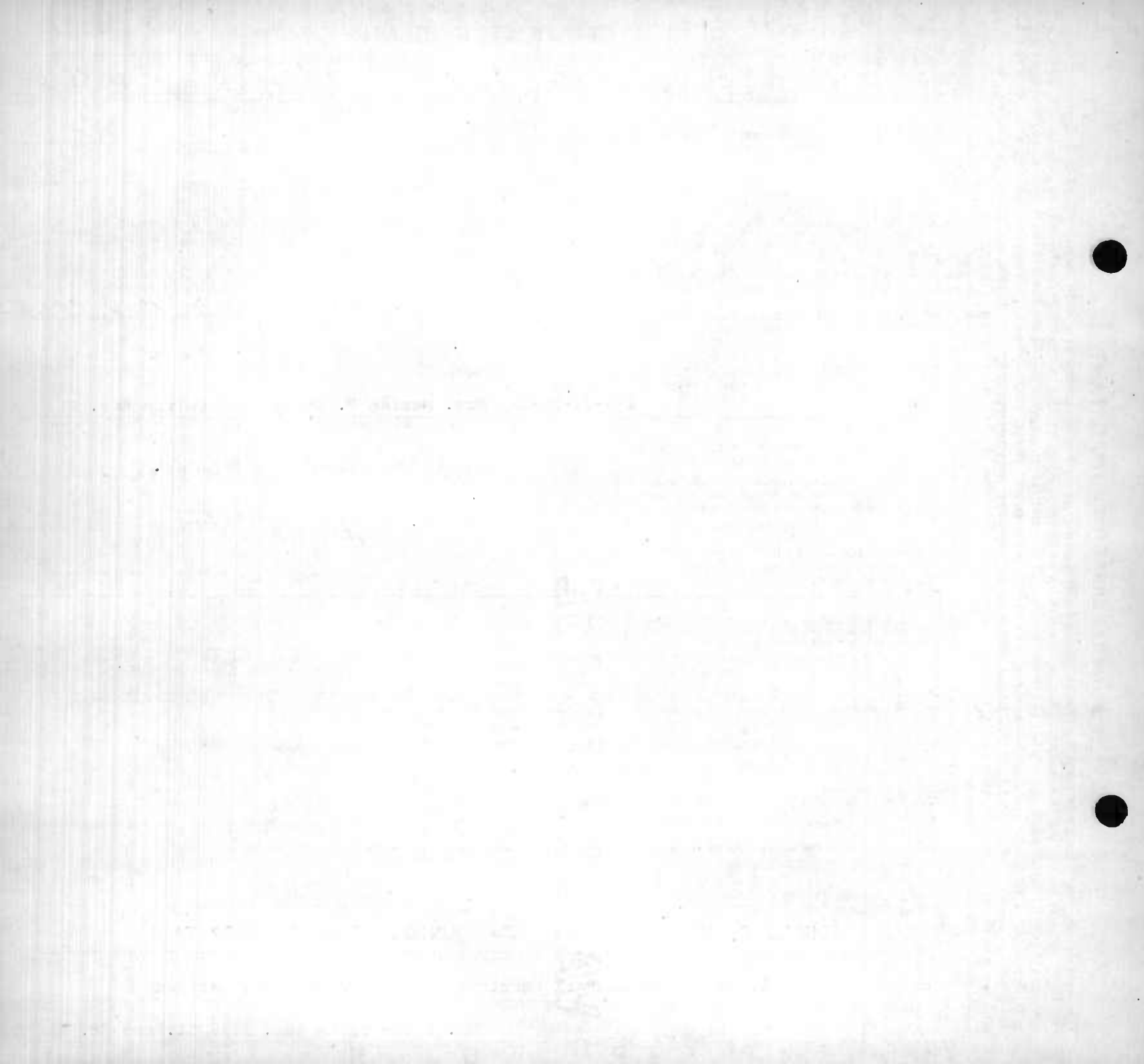
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

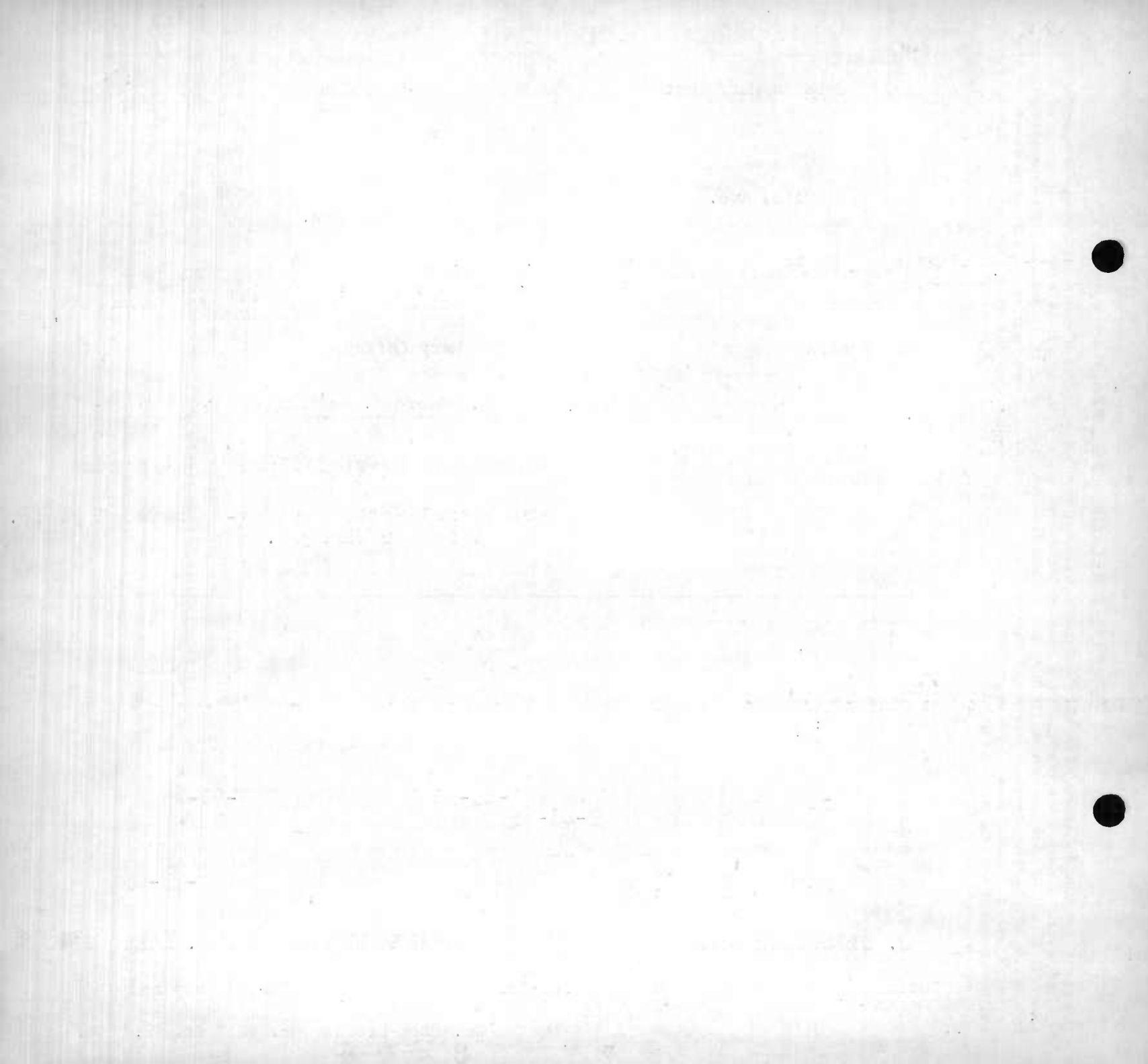
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| 65 9847 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9847 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | DATE AND HOUR OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Arthur Eugene Pawley</i> | | 9/24/65 1:55 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>12-02</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Union Memorial Hospital</i> | | D. STREET ADDRESS (If rural, give location) <i>415 Calvin Avenue</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Separated</i> | 8. DATE OF BIRTH <i>4/9/1895</i> | 9. AGE (In years lost birthday) <i>70</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Baltimore Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>United States</i> | | 13. FATHER'S NAME <i>JAMES S. PAWLEY</i> | | 14. MOTHER'S MAIDEN NAME <i>IDA M. KILLEN</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>215-22-2412</i> | | 17. INFORMANT ADDRESS <i>Mrs. Marian P. Dally 415 Calvin Ave. 21218</i> | |
| 18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) <i>myocardial infarction</i> DUE TO (B) <i>ascending nephritis</i> DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION <i>3 9/1/65</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Benign prostatic Hypertasia</i> | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>8/29 1965</i> to <i>9/24 1965</i> , that (I) (we) last saw the deceased alive on <i>9/24/65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Donald G. Hall</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>9/24/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>DONALD G. HALL</i> | | 23D. ADDRESS <i>UNION MEMORIAL HOSPITAL</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>9/27/65</i> | | 24C. NAME of CEMETERY or CREMATORY <i>Loudon Park Cemetery</i> | |
| | | | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 27 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>Wm. Cook-Brooks Inc. 1217 St. Paul St. 21202</i> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------|
| BIRTH NO. 65 9848 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Estella Mary Gunther | | 9/22/65 8:10 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE Maryland B. COUNTY 12-07 | | | |
| 2735 Miles Ave. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 2735 Miles Ave. | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH Feb. 8, 1881 | 9. AGE (In years last birthday) 84 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | |
| 13. FATHER'S NAME John Mannion | | 14. MOTHER'S MAIDEN NAME Mary Coffay | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT ADDRESS Mr. Edward J. Gunther 416 W. 23rd. St. 21211 | |
| 18. 334X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Longestive heart failure DUE TO arteriosclerotic cerebro-vascular changes. | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH 4 months several years. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | (B) DUE TO | | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <u>(I)</u> (this hospital) attended the deceased from <u>1-15-51</u> 19 to <u>9-22-65</u> 19, that <u>(I)</u> (we) last saw the deceased alive on <u>9-21-65</u> 19 and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(I)</u> (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>E. Ellsworth Cook</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9-23-65 | |
| 23C. PHYSICIAN'S NAME (Type) E. ELLSWORTH COOK | | 23D. ADDRESS 2431 MARYLAND AVENUE. BALTO 21218MD | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9/25/65 | 24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | 25B. NAME OF REGISTRAR <i>Robert E. Farley</i> | | 25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Inc. 1217 St. Paul St. 21202 | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | 65 9849 | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 9849 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|------------------------------------------------------------------------------|--|-----------------------------|--|
| 1. NAME OF DECEASED (Type or Print) <i>Sister Mary Magdalen</i> | | | | 2. DATE AND HOUR OF DEATH <i>9-23-65 5:30 PM</i> | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore City</i> | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Bon Secours Hospital</i> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>27-13</i> | | | | | |
| D. STREET ADDRESS (If rural, give location) <i>5T Mary's Seminary-Roland Park</i> | | | | | | | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Single</i> | | 8. DATE OF BIRTH <i>10-12-76</i> | 9. AGE (In years lost birthday) <i>89</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Religious</i> | | 11. BIRTHPLACE (State or foreign country) <i>Kentucky</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | |
| 13. FATHER'S NAME <i>HENRY Kohls</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Caroline Langemann</i> | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>—</i> | | 17. INFORMANT <i>Records of SRS of Divine Providence</i> | | ADDRESS | | | |
| 18. <i>422.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) <i>congestive heart failure.</i> DUE TO (B) <i>Arteriosclerotic C.V.D.</i> DUE TO (C) <i>—</i> | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>8-21-65</i> 19 <i>65</i> to <i>9-23</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>5:30 PM 9-23 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>Byong Hack Kim</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>Sept. 23, 1965</i> | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>B. H. KIM</i> | | | | 23D. ADDRESS <i>Bon Secours Hospital</i> | | | | | |
| 24A. BURIAL CREATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>9-27-65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>CEM SRS of DIVINE PROVIDENCE</i> | | 24D. LOCATION (City, town, or county) (State) <i>MELOUBOURNE KENTUCKY</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 27 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Jones</i> | | 25C. FUNERAL DIRECTOR <i>CHAS. F. EVANS & SON</i> | | ADDRESS <i>8802 Harford Rd</i> | | | |

1
H-655

65 9850

BALTIMORE CITY HEALTH DEPARTMENT

65 9850

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

WALTER EUGENE HARMON Jr

2. DATE AND HOUR PRONOUNCED DEAD

September 24, 1965 6:40 A

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Mt. Airey

D. STREET ADDRESS (If rural, give location)

RFD 1

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

May 10, 1958

9. AGE (In years last birthday)

7

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Frederick, Maryland

12. CITIZEN OF WHAT COUNTRY?

US

13. FATHER'S NAME

Walter Eugene Harmon, Sr

14. MOTHER'S MAIDEN NAME

Janet Staley

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

ADDRESS

Walter Eugene Harmon, Sr. (Same as item 2)

18. E903.10

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Massive Hemorrhage
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Laceration of Heart and Great Vessels
DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Mt. Airey, Md.

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

9 22 '65 P

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Fell through glass in storm door.

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion

resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/24/65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

Sept 27, 1965

23C. NAME of CEMETERY or CREMATORY

Frederick Memorial Park

23D. LOCATION

(City, town, or county)

(State)

Frederick, Maryland

24A. DATE REC'D BY HEALTH DEPT.

SEP 27 1965

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

M.R. Etchison & Son, Frederick, Maryland

ADDRESS

WALTER R. HARRIS

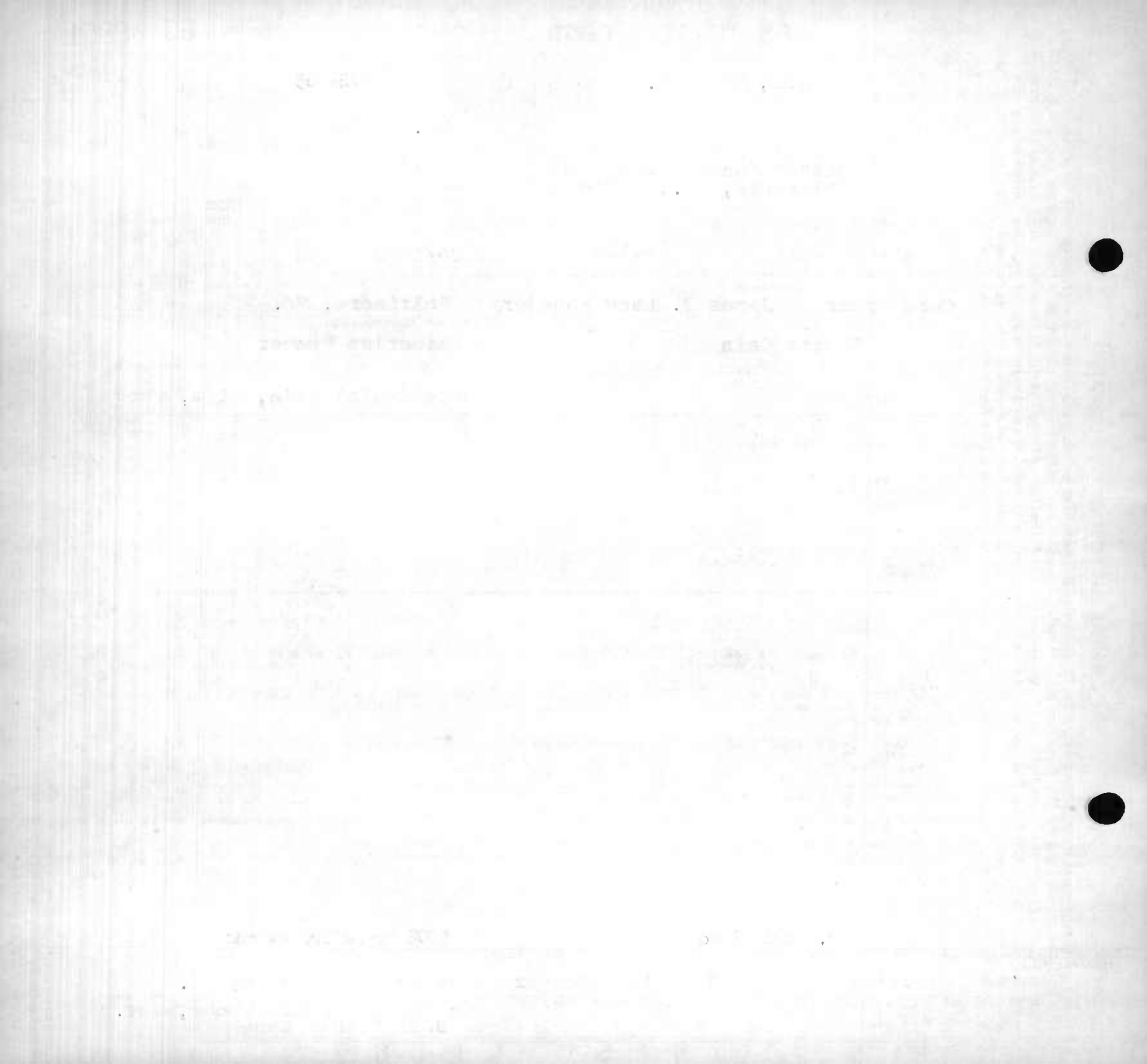
WALTER R. HARRIS

Class of

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9851 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9851 | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------------------------------------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| (Type or Print) | | | | CAIN, ROBERT G. | | 9/24/65 10 ⁰⁰ A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | | | A. STATE | | B. COUNTY | |
| If not in hospital or institution, give street address or location | | | | Md., 21206 | | 76-01 | |
| 5465 Cedonia Avenue Baltimore, Md., 21206 | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore | |
| | | | | D. STREET ADDRESS (If rural, give location) | | 5465 Cedonia Avenue | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | 10. Under 1 Yr. Months Days | | |
| male | white | married | 8/26/1905 | 60 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | |
| Core Maker James J. Lacy Foundry | | | Baltimore, Md. | | | | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | | | |
| Thomas Cain | | | Catherine Hamper | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | |
| no | | | | | Agnes Coufal Cain, wife, above | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | (A) Carcinoma of Rt Lung with metastasis | | | 2 months | |
| ANTECEDENT CAUSES | | | (B) DUE TO | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (C) DUE TO | | | | |
| II | | | Diabetes mellitus | | | 5 yrs | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | III in Baltimore City, give exact location) | |
| | | | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3-12-1962 to 9-24-1965, that (I) (we) lost saw the deceased olive on 9-24-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| Dr. Jurl Hinno | | | | | | 9-24-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| | | | | 5002 Frankford Avenue | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 9/27/65 | | Holy Redeemer Cemetery | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| SEP 27 1965 | | Robert E. Taylor, M.D. | | Schimunek Funeral Home, Inc. | | 3331 Brehms Lane | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | | | BALTIMORE CITY DEPARTMENT | | | | 65 9852 | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|---------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | | Registered No. | | | |
| 1. NAME OF DECEASED (Type or Print) <i>Glorioso Sadie</i> | | | | 2. DATE AND HOUR OF DEATH <i>9/21/65</i> <i>3²⁵ P</i> M. | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>8-01</i> | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>36 Franklin Square Hosp</i> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | | | | | |
| (If not in hospital or institution, give street address or location) | | | | D. STREET ADDRESS (If rural, give location) <i>3015 Erdman Ave</i> | | | | | | | |
| 5. SEX <i>F</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>WIDOWED</i> | | 8. DATE OF BIRTH <i>12/20/1895</i> | 9. AGE (In years last birthday) <i>69</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>at home</i> | | | | 11. BIRTHPLACE (State or foreign country) <i>New Roads Louisiana</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U S</i> | |
| 13. FATHER'S NAME <i>Frank De Mico</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Mary Gloriosio</i> | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS <i>Vincent Gloriosio, son, above</i> | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>465 X I</i> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) <i>Bulmonary Embolism</i> DUE TO (B) DUE TO (C) | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | |
| 19A. DATE OF OPERATION <i>9/14/65</i> | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>fair</i> | | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9/8</i> 19 <i>65</i> to <i>9/21</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | |
| 23A. SIGNATURE <i>Byung Koo Kim</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED | | | |
| 23C. PHYSICIAN'S NAME (Type) <i>Byung Koo Kim</i> | | | | M.D. 23D. ADDRESS <i>Franklin Square Hosp</i> | | | | | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i> | | | | 24B. DATE <i>9/25/65</i> | | | | 24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer Cemetery</i> | | | |
| 24D. LOCATION <i>Baltimore, Md.</i> | | | | 24E. LOCATION (City, town, or county) (State) | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 27 1965</i> | | | | 25B. NAME OF REGISTRAR <i>Robert E. Johnson</i> | | | | 25C. FUNERAL DIRECTOR ADDRESS <i>Schimunek Funeral Home, Inc. 3331 Brehms Lane</i> | | | |

Franklin Square Hotel
F W

Frank De Mico

Baltimore

Hardy

Louisiana

1/1/1917

3-17 Elyman Ave

Baltimore

M 4

1/14/17 for

Lynd Koo Kim
Lynd Koo Kim

Franklin Square Hotel

1/18

✓

BIRTH NO.

65

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

NANCY Lee ENGLE

2. DATE AND HOUR PRONOUNCED DEAD

September 23, 1965 12:01 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

844 W. Baltimore Street

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Feb. 15, 1942

9. AGE (In years
last birthday)

22

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Waitress

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

John R. Gilbert

14. MOTHER'S MAIDEN NAME

Thelma E. Woodward

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

218-40-0082

17. INFORMANT

ADDRESS

John L. Gilbert, Owings Mills, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Generalized Sepsis

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) Infected Infarction of Spleen with Extension
into Subdiaphragmatic area due to

(C) Postpartum retained Secundinae with infection.

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/23/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Sept. 25, 1965 Finksburg

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

Finksburg, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 27 1965

Robert E. Farber, M.D.

J.F. Eline & Sons, Reisterstown, Md.

WILLIAM C. CROFT

Feb. 11, 1963

Noted

Maryland

Noted

William C. Croft

John E. Gilbert

228-10-0023 John E. Gilbert, Orange Mills, Md.

to

Noted Feb. 22, 1963

Richmond, Md.

J. V. Allen & Son, Rockville, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|--------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|--------------------------------------------------------------------------|-------------------------------------------|
| BIRTH NO. 65 9854 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9854 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Louise Johnson | | 2. DATE AND HOUR OF DEATH Sept. 22 1965 11:05 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HDSPITAL DR INSTITUTION (If not in hospital or institution, give street address or location) Bar. Wil. Bar. Home 2100 W. Cold Spring Lane | | A. STATE Md. B. CDUNTY 14-03 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 2210 W. Cold Spring Lane | | | |
| 5. SEX Female | 6. RACE Colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH May 23-1877 | 9. AGE (In years last birthday) 88 | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Reisterstown Md | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. | | 13. FATHER'S NAME Louis Wilson | | 14. MOTHER'S MAIDEN NAME Cossie Shadows | |
| 15. Was Deceased Ever in U. S. Armed Forces (If yes, give war or dates of service) No | | 16. SECURITY NO. None | | 17. INFORMANT ADDRESS Susie D. Wilson 2210 McCulloch St Baltimore Md | |
| 18. 443 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | CAUSE OF DEATH (A) Hypertensive arteriosclerotic C.V.D. (B) DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-14-1965 to 9-22-1965, that (I) (we) last saw the deceased alive on 9-21-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE C.R. Campbell | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9-23-65 | |
| 23C. PHYSICIAN'S NAME (Type) C.R. Campbell | | 23D. ADDRESS M.D. 1618 W. North Ave. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/26/65 | | 24C. NAME OF CEMETERY or CREMATORY St. Lukes | |
| 24D. LOCATION (City, town, or county) (State) Reisterstown Md | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR J.F. Fling | |
| 25D. ADDRESS Reisterstown | | | | | |

Highly variable

10-15

10-15

10-15

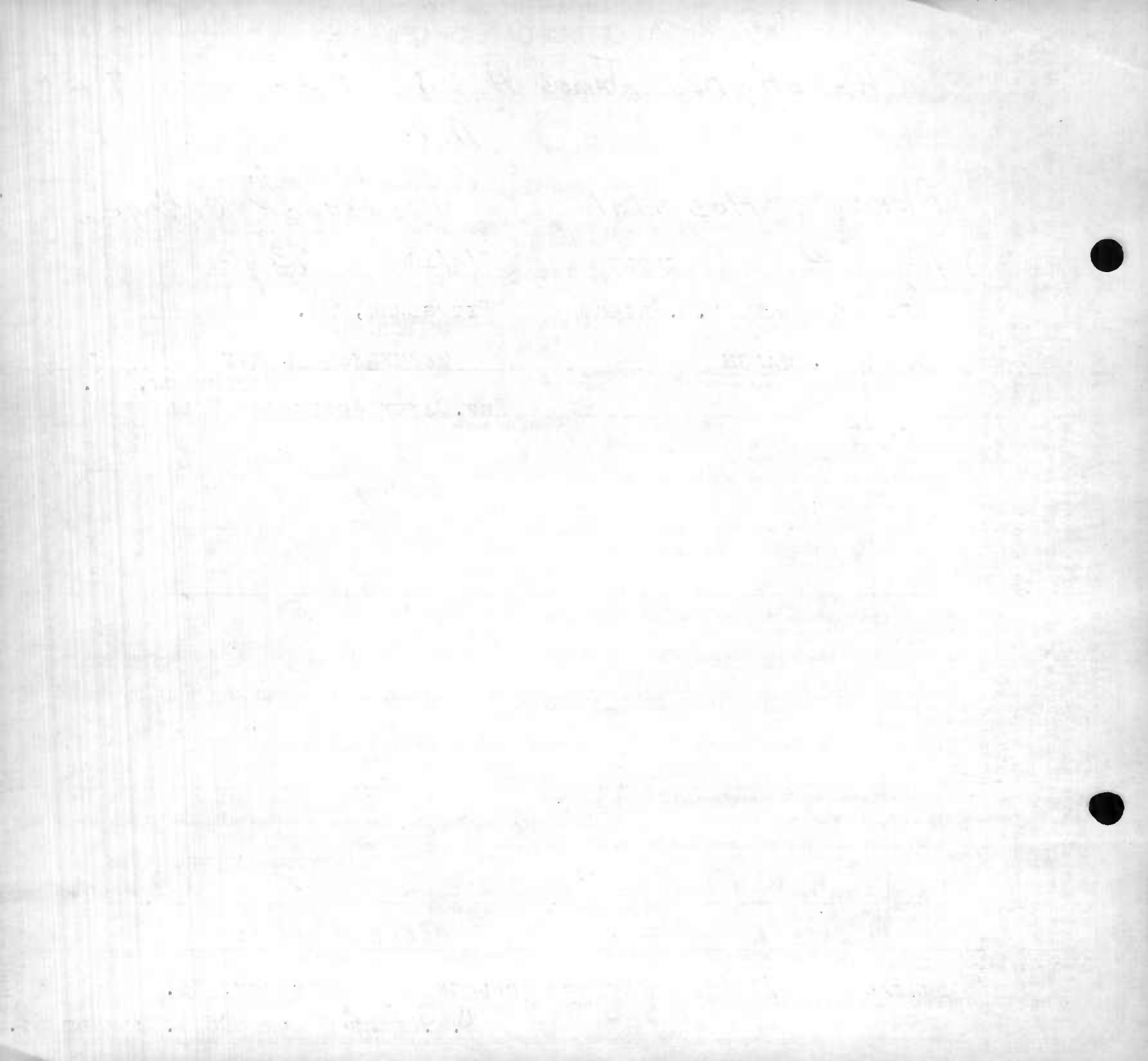
10-15

10-15

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Certificate of Death | | Registered No. 65 9855 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------|-----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|--|
| BIRTH NO. 65 9855 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Walsh, Rev James A. S.J.</i> | | 2. DATE AND HOUR OF DEATH <i>9-22-65 7:15 A.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Mercy Hospital.</i> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>Balt.</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Woodstock 3300</i> D. STREET ADDRESS (If rural, give location) <i>Woodstock College</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>SINGLE</i> | 8. DATE OF BIRTH <i>7/2/1892</i> | 9. AGE (In years last birthday) <i>73 yrs</i> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Religious R.C. Priest</i> | | |
| 11. BIRTHPLACE (State or foreign country) <i>Pittsburg, Pa.</i> | | | 12. CITIZEN OF WHAT COUNTRY? | | | | |
| 13. FATHER'S NAME <i>Thomas F. Walsh</i> | | | 14. MOTHER'S MAIDEN NAME <i>Catherine Murrey</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>Rev. Caye Woodstock College</i> | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) <i>Massive upper Gastrointestinal Bleeding.</i> (B) <i>Peptic ulcer</i> (C) | | INTERVAL BETWEEN ONSET AND DEATH <i>20 hrs.</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>19</i> , that (I) (we) last saw the deceased alive on <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Vicente R. Carag Jr.</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>Sept. 20, 1965</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>VICENTE R. CARAG JR.</i> | | | | 23D. ADDRESS <i>MERCY HOSPITAL</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>9/25/65</i> | | 24C. NAME of CEMETERY or CREMATORY <i>WOODSTOCK COLLEGE</i> | | 24D. LOCATION (City, town, or county) (State) <i>WOODSTOCK, MD.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 27 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert S. Taylor</i> | | 25C. FUNERAL DIRECTOR <i>N.W. MEARS & SON 805 N. CALVERT ST.</i> | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. 65 9856 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 9856 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Anna M. Beall Beck | | 2. DATE AND HOUR OF DEATH Sept. 22, 1965 7:09 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Clifton Nursing Home | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3329 Mondawmin Ave., | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 9-29-1881 | 9. AGE (In years last birthday) 83 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY = | | 11. BIRTHPLACE (State or foreign country) Md. | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 13. FATHER'S NAME John Schott | | | 14. MOTHER'S MAIDEN NAME Margaret Robinson | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS Catherine Kaltenbach 1936 Mt. Royal Ter. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) Myocardial Insufficiency DUE TO (B) Generalized Arteriosclerosis DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH One day years | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 8, 1964 to Sept. 22, 1965, that (I) (we) last saw the deceased alive on Sept. 21, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. Yes. | | | | | |
| 23A. SIGNATURE Maurice E. Shamer | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Sept. 23-1965 | |
| 23C. PHYSICIAN'S NAME (Type) Maurice E. Shamer | | 23D. ADDRESS 3300 W. North Ave., | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-25-1965 | | 24C. NAME of CEMETERY or CREMATORY Lorraine Park | |
| | | | | 24D. LOCATION (City, town, or county) (State) Woodlawn Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | 25B. NAME OF REGISTRAR Robert E. Fisher | | 25C. FUNERAL DIRECTOR ADDRESS G. Howard Strong 3207 W. North Ave., | |

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9858 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 9858 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Lawrence Albert Robinson | | | 2. DATE AND HOUR OF DEATH Sept. 24, 1965 4: 50 A M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital Wyman Pk. Drive & 31st Street | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE New Jersey B. COUNTY V-278 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Pitman D. STREET ADDRESS (If rural, give location) 52 S. Broadway | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 4/24/06 | 9. AGE (In years last birthday) 59 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 2nd Engineer | | 10B. KIND OF BUSINESS OR INDUSTRY Seafarer | 11. BIRTHPLACE (State or foreign country) Pa. | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Charles Robinson | | | 14. MOTHER'S MAIDEN NAME Mary SHANAHAN | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 6. SOCIAL SECURITY NO. 154-05-7246 | ADDRESS US PHS Hospital, Balto, Md. | | |
| 18. I 191.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. If means the disease, injury or complication which caused death.) Bronchopneumonia Pulmonary edema Cachexia DUE TO (A) Squamous cell carcinoma skin (B) of left face with very extensive local invasion (C) Years | | | INTERVAL BETWEEN ONSET AND DEATH Days Months | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Aug 16 1965 to Sept 24 1965 , that (I) (we) last saw the deceased alive on Sept 24 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE James M. Weaver M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 9/24/65 | |
| 23C. PHYSICIAN'S NAME (Type) James M. Weaver, Medical Director M.D. | | | 23D. ADDRESS US PHS Hospital, Balto, Md. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION | 24B. DATE 9/27/65 | 24C. NAME of CEMETERY or CREMATORY Chelton Hills | | 24D. LOCATION (City, town, or county) (State) Phila PA. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | 25B. NAME OF REGISTRAR Robert E. Faldut | | 25C. FUNERAL DIRECTOR WEATHERBY Funeral Home PITMAN NJ ADDRESS 28 W. 1st St. Balto Md | |



1
H-500

65 9859

BALTIMORE CITY HEALTH DEPARTMENT

65 9859

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) MARGARET HAYNIE
2. DATE AND HOUR PRONOUNCED DEAD September 22, 1965 7:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 9.9.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
4124 Hayden Ct.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4124 Hayden Ct. Brooklyn Park

5. SEX Female 6. RACE white 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married 8. DATE OF BIRTH May 12, 1931 9. AGE (in years last birthday) 34

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk 10B. KIND OF BUSINESS OR INDUSTRY Store 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joseph C. Fonte 14. MOTHER'S MAIDEN NAME Helen unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 212-28-6658 17. INFORMANT Kenneth Haynie 50 Main St Lexington Park

18. 201X I CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Hodgkin's disease
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK [] NOT WHILE AT WORK [] 21F. HOW DID INJURY OCCUR?

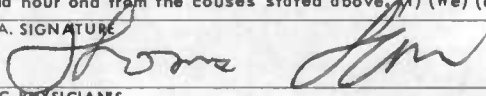
22. I certify that I held on Inquiry [] Inspection [X] Autopsy [] and that on this basis, death in my opinion resulted from: Natural cause [X] Accident [] Suicide [] Homicide [] Undetermined manner []

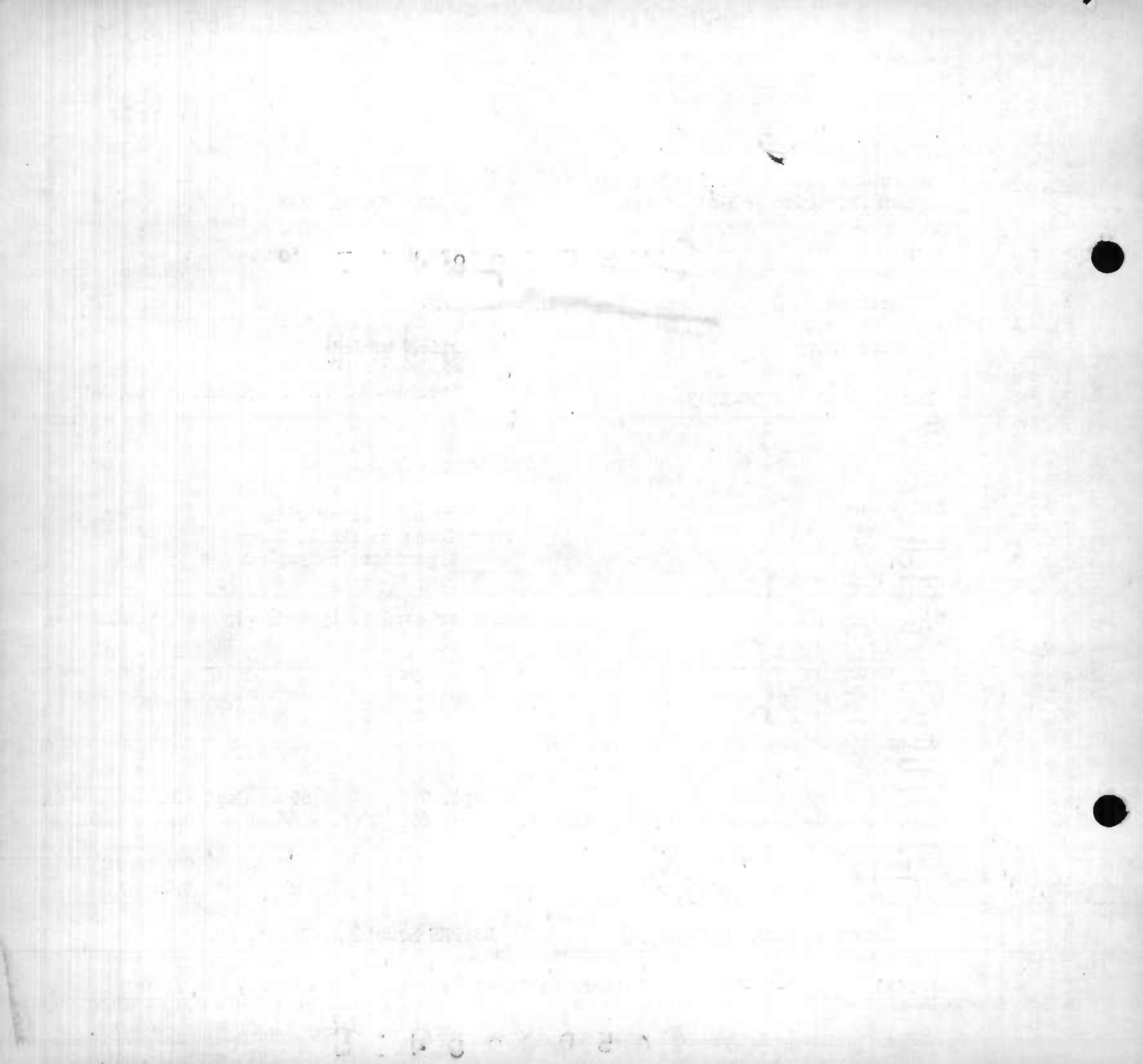
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breitenecker, M.D. CHIEF MEDICAL EXAMINER [] M.D. ASSISTANT MEDICAL EXAMINER [X] ASSOCIATE MEDICAL EXAMINER [] DATE SIGNED Sept. 22, 1965

23A. BURIAL CREMATION, REMOVAL (Specify) Burial 23B. DATE 9/27/65 23C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery 23D. LOCATION (City, town, or county) (State) Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 24B. NAME OF REGISTRAR Robert E. Fairbank 24C. FUNERAL DIRECTOR ADDRESS 24D. FUNERAL DIRECTOR ADDRESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY DEPARTMENT CERTIFICATE OF DEATH | | | | Registered No. 65 9860 | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 65 9860 | | | M.E. CASE NO. | | |
| 1. NAME OF DECEASED (Type or Print) CORDUS WILLIAM EMBRY | | | 2. DATE AND HOUR OF DEATH Sept. 21, 1965 5 P M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital Wyman Pk. Drive & 31st Street | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY AA C. CITY OR TOWN (If outside city limits, write RURAL and give township) Riviera Beach D. STREET ADDRESS (If rural, give location) 8436 Church Road | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED MARRIED | 8. DATE OF BIRTH 7/22/05 | 9. AGE (In years last birthday) 60 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY Coast Guard | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Wess Embry | | | 14. MOTHER'S MAIDEN NAME Alice Burden | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes CG 1928-1953 | | 16. SOCIAL SECURITY NO. ? | | 17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md. | |
| 18. 15611 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary edema ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Adenocarcinoma liver with metastases to skull, lungs & periaortic lymph nodes | | | INTERVAL BETWEEN ONSET AND DEATH Hours Months | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Left ventricular cardiac hypertrophy | | | Months | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept. 7 19 65 to Sept. 21 19 65 , that (I) (we) last saw the deceased alive on Sept. 21 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE  M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 9/22/65 | |
| 23C. PHYSICIAN'S NAME (Type) Thomas J. Lau, Surgeon (R) | | | | 23D. ADDRESS US PHS Hospital, Balto, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-24-1965 | | 24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery | |
| 24D. LOCATION Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Fisher | | 25C. FUNERAL DIRECTOR George J. Gonce | | 25D. ADDRESS 4001 Ritchie Hwy. Baltimore 25, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9861 | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| BIRTH NO. 65 9861 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) John Mc Dougall | | 2. DATE AND HOUR OF DEATH 9-21-65 9 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore City D. STREET ADDRESS (If rural, give location) 1015 N. Woodington Ave. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH June 9, 1906 | 9. AGE (In years lost birthday) 59 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer | | 10B. KIND OF BUSINESS OR INDUSTRY Advertisement on paper bags | | 11. BIRTHPLACE (State or foreign country) Philadelphia, Penna. | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 13. FATHER'S NAME John Mc Dougall | | 14. MOTHER'S MAIDEN NAME Sarah Lym | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 184-05-7919 | | 17. INFORMANT ADDRESS 1015 Woodington Rd. Baltimore, Md. 21229 Mrs. Catherine E. Mc Dougall | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Coronary Arteriosclerosis | | CAUSE OF DEATH (A) Myocardial Infarction DUE TO (B) Coronary Arteriosclerosis DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8:35 PM 9/21 1965 to 9 PM 9/21 1965 , that (I) (we) last saw the deceased alive on Sept 21 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE W E Signor | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Sept 22, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) William E. Signor | | 23D. ADDRESS St. Agnes Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/25/1965 | | 24C. NAME of CEMETERY or CREMATORY Loudon Park | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS Calonsville, Md. Easton Funeral Home | | | |

Printer

Advertisement on paper bags

Philadelphia, Penn.

U. S. A.

Small form

John W. Lippitt

191-05-7573

1005 Woodington St. Baltimore, Md. 21205
Mr. Lippitt, 1005 Woodington St. Baltimore, Md. 21205

U. S. A.

Small form

Advertisement

Printer

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| BIRTH NO. 65 9862 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9862 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) GEORGE WASHINGTON BELLMANN | | | 2. DATE AND HOUR OF DEATH 9/24/65 7:45 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL | | | A. STATE MARYLAND B. COUNTY BALTO. | | |
| (If not in hospital or institution, give street address or location) | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | |
| | | | D. STREET ADDRESS (If rural, give location) 2816 MUNSTER ROAD | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED, WIDOWED | 8. DATE OF BIRTH 3/17/84 | 9. AGE (In years last birthday) 81 | If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WHITE CROWN CORK & SEAL CO. | | | 11. BIRTH PLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME FRED BELLMANN | | | 14. MOTHER'S MAIDEN NAME MARY HARRINGTON | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 213-01-0325 | | 17. INFORMANT MRS. ELGERT ADDRESS PATIENT 2816 MUNSTER Rd. |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Coronary heart disease | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. pneumonia | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (H) (this hospital) attended the deceased from 6:30 PM 9/20 19 65 to 7:45 AM 9/24 19 65 , that (H) (we) last saw the deceased alive on 7:45 AM 9/24 19 65 and that in (H) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Robert N. Whitlock | | | | 23B. DATE SIGNED 9/24/65 | |
| 23C. PHYSICIAN'S NAME (Type) ROBERT N. WHITLOCK | | | | 23D. ADDRESS UNION MEMORIAL HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/27/65 | | 24C. NAME OF CEMETERY or CREMATORY OAK LAWN | |
| 24D. LOCATION (City, town, or county) (State) BALTO. Co. MD. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Farber, M.D. | | 25C. FUNERAL DIRECTOR S. W. Hoffmann ADDRESS 3218 HUDSON ST. 21224 | | | |

UNION MEMBERS

ROBERT H. WILSON

65 9863

BALTIMORE CITY HEALTH DEPARTMENT

65 9863

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES WADE

2. DATE AND HOUR PRONOUNCED DEAD

September 25, 1965 9:25 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Bon Secour Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE
Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3515 Springdale Ave.

5. SEX

male

6. RACE

negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)
Never Married

8. DATE OF BIRTH

Nov. 26, 1930

9. AGE (In years
last birthday)

34

If Under 1 Yr. If Under 24 Hrs.
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

James E. Wade Sr.

14. MOTHER'S MAIDEN NAME

Marie Shipley

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give year or dates of service)

Yes

WWII

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Marie Wade 3515 Springdale Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Generalized peritonitis
DUE TO
Gunshot wound of the abdomen

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

300 N. Fulton Ave.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

9

21

65

8:10

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

Shot during altercation

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenacker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Sept. 25, 1965

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/29/65

23C. NAME OF CEMETERY or CREMATORY

Baltimore Natl. Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 27 1965

24B. NAME OF REGISTRAR

Robert E. Farley

24C. FUNERAL DIRECTOR

George H. Klon 1348 N. Calhoun St.

ADDRESS

WALTER FORGE

ONE EIGHT

100

100

James E. Wade Sr.

Marie Shipley

Never married Nov. 20, 1930 34

Baltimore, Md.

3515 Springdale Ave.

Marie Wade 3515 Springdale Ave.

Burial 4/29/05 Baltimore Natl. Cem. Baltimore, Md.

1 2 3 4 5

FUNERAL DIRECTOR: IMPORTANT

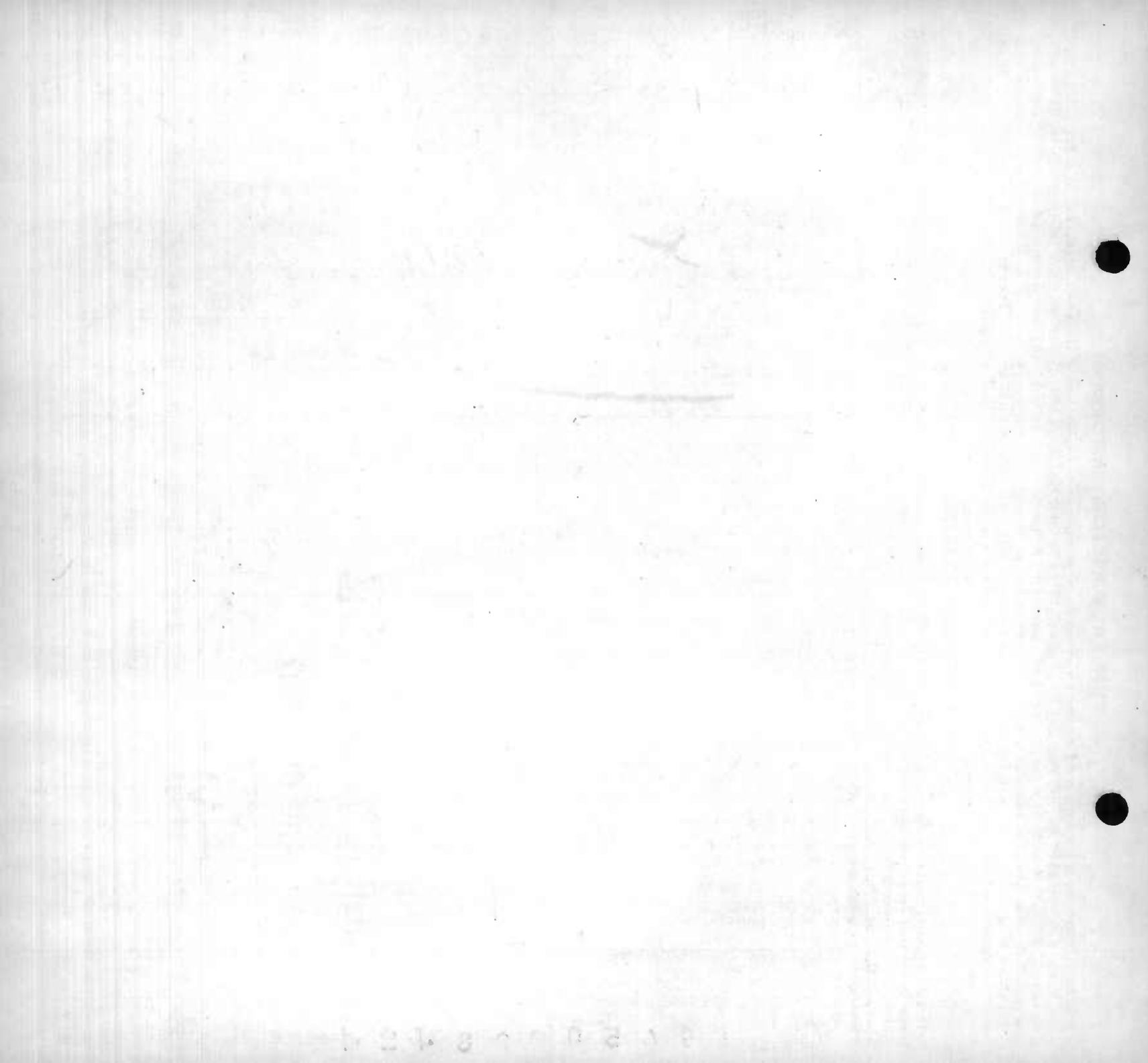
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 65 9864 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| BIRTH NO. | | | | 65 9864 | |
| M.E. CASE NO. | | | | 65 9864 | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | |
| Ella Baker | | | | Sept. 23, 1965 8:30 p.m. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | |
| 1538 Leslie St. | | | | Maryland 15-01 | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | D. STREET ADDRESS (If rural, give location) | |
| Baltimore | | | | 1538 Leslie St. | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | |
| Female | | Negro | | Widowed | |
| 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| June 9, 1899 | | 66 | | 10B. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | |
| Maryland | | U.S.A. | | John Wilson | |
| 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| Elizabeth Young | | No | | 17. INFORMANT ADDRESS | |
| Mildred Baker | | 1538 Leslie St. | | 18. CAUSE OF DEATH | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | 20. INTERVAL BETWEEN ONSET AND DEATH | | 21. ANTECEDENT CAUSES | |
| (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) | | Two weeks | | DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | |
| 331X I | | Cerebral hemorrhage | | Arteriosclerosis + hypertension | |
| II | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 22. I certify that (I) (this hospital) attended the deceased from 9-9-1965 to 9-23-1965, that (I) (we) last saw the deceased alive on 9-23-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) | |
| Frank A. Saunders | | 9-25-65 | | 23D. ADDRESS | |
| M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | M.D. 1029 N. Stricker St. | | 24A. BURIAL CREMATION, REMOVAL (Specify) | |
| Burial | | 24B. DATE 9/27/65 | | 24C. NAME OF CEMETERY or CREMATORY | |
| New Cathedral Cem. | | 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. | |
| Baltimore, Md. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| SEP 27 1965 Robert E. Taylor, M.D. | | 25D. ADDRESS | | 25E. FUNERAL DIRECTOR | |
| 1348 N. Calhoun St | | 25F. ADDRESS | | 25G. FUNERAL DIRECTOR | |
| 1348 N. Calhoun St | | 25H. ADDRESS | | 25I. FUNERAL DIRECTOR | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

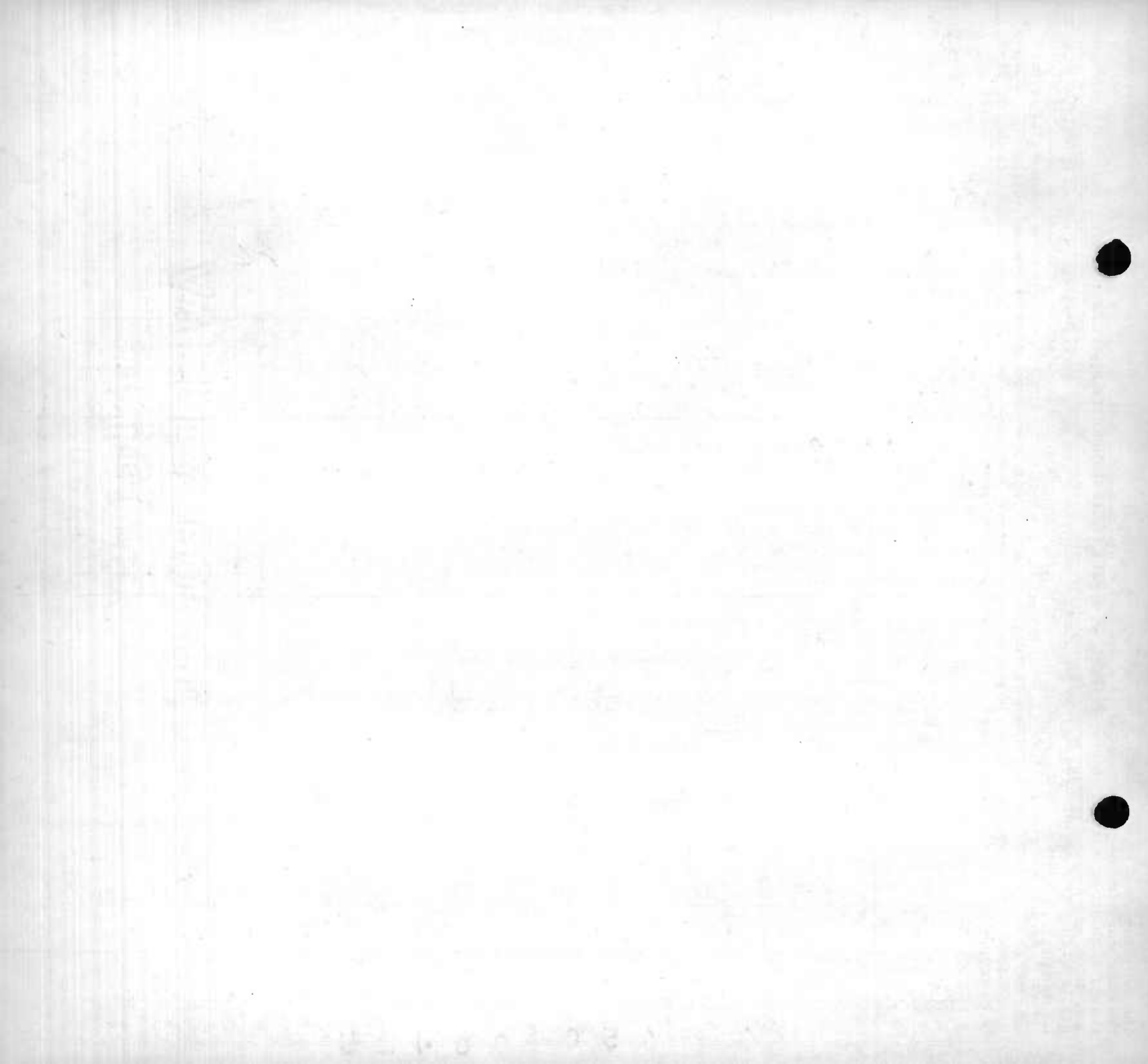
| BIRTH NO. 65 9865 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9865 | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-----------------------------------------------------------------------|------------------------|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) CHARLES H. PARKER | | | |
| 2. DATE AND HOUR OF DEATH 9/26/65 8:45 A.M. | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND Lutheran Hosp of Maryland | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY B. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hosp of Maryland | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| D. STREET ADDRESS (If rural, give location) 1131 N. STRICKER ST | | | | | | | |
| 5. SEX Male | 6. RACE C | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH 8/31/1919 | 9. AGE (In years last birthday) 46 | If Under 1 Yr. Months | If Under 24 Hrs. Days | If Under 24 Hrs. Hours |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MD. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 16-05-3535 | | 17. INFORMANT Alberta Hanson | | ADDRESS 516 N. Carrollton Ave | |
| 18. 450.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Mesenteric Thrombosis | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Severe atherosclerosis of mesenteric vessels. | | | | (B) DUE TO | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. severe dehydration & electrolyte imbalance | | | | (C) DUE TO | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/24 19 65 to 9/26 19 65 , that (I) (we) last saw the deceased alive on 9/26 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Cheng Soo & him | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/26/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-25-65 | | 24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem. | | 24D. LOCATION (City, town, or county) (State) Baltimore Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor M.D. | | 25C. FUNERAL DIRECTOR George J. Folan | | ADDRESS 1348 N. Calhoun St | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9866 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9866 | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Gee, Allen</u> | | | | 2. DATE AND HOUR OF DEATH <u>Sept. 24, 1965</u> <u>9:30 A.M.</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY HOSPITAL</u> | | (If not in hospital or institution, give street address or location) | | A. STATE <u>Maryland</u> | | B. COUNTY <u>Baltimore City</u> | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> <u>15-03</u> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <u>1728 N Bentlow Street.</u> | | | |
| 5. SEX <u>M</u> | | 6. RACE <u>Negro</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>MARRIED.</u> | | 8. DATE OF BIRTH <u>2-18-99</u> | |
| 9. AGE (In years lost birthday) <u>66</u> | | 10. Under 1 Yr. Months: Days: Hours: Min. | | 11. Under 24 Hrs. Hours: Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postal Worker</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u> | | 11. BIRTHPLACE (State or foreign country) <u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Allen F. Gee</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary E. Jones</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes WWI</u> | | | | 16. SOCIAL SECURITY NO. <u>219-40-4314</u> | | 17. INFORMANT <u>Mary E. Gee</u> | |
| 18. <u>46581</u> | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) <u>Pulmonary Embolism</u> | | <u>1 hr.</u> | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>11 SEPT 19 65</u> to <u>24 SEPT 19 65</u> , that (I) (we) last saw the deceased alive on <u>29 SEPT 19 65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Richard D. Biggs Jr.</u> | | | | 23B. DATE SIGNED <u>24 Sept 65</u> | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>RICHARD D. BIGGS JR.</u> | | | | 23D. ADDRESS <u>UNIVERSITY HOSP.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9-28-65</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Balto. Natl. Cem.</u> | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 27 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR <u>George H. Kilar</u> | | ADDRESS <u>1728 N. Calhoun St</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. 65 9867 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9867 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Mary Ernst | | 2. DATE AND HOUR OF DEATH Sept. 25-65 12:30 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Fairfield Convalescent Home | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore - Md. | | | |
| | | D. STREET ADDRESS (If rural, give location) 413 N. Milton Ave. | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH Dec. 27-1877 | 9. AGE (In years last birthday) 87 yrs. | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore - Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME VALENTINE | | 14. MOTHER'S MAIDEN NAME UNKNOWN | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| 18. 422.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) DUE TO Congestive Heart Failure (B) DUE TO Myocardial Insufficiency (C) Generalized Atheroma Anasarca | | INTERVAL BETWEEN ONSET AND DEATH 3 days | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? Ill in Baltimore City, give exact location | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from June 1 - 1957 to Sept 25 - 1965, that (I) (we) last saw the deceased alive on Sept 24 - 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE WM G GEYER, M.D. | | 23B. DATE SIGNED Sept 25-65 | | 23C. PHYSICIAN'S NAME (Type) WM G GEYER, M.D. | |
| 23D. ADDRESS 156 N. Milton Ave. | | 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | | |
| 24B. DATE 9-28-65 | | 24C. NAME OF CEMETERY or CREMATORY LOUDON PK. Cem. | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Hartley Miller - 2334 Jefferson St. | |

65 9868

BALTIMORE CITY HEALTH DEPARTMENT

65 9868

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED

(Type of Print)

CARRIE JANE DIXON

2. DATE AND HOUR PRONOUNCED DEAD

September 22, 1965 5:50 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1611 N. Gay Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

Aug. 5, 1900

9. AGE (In years last birthday)

65

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, e.g., if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTH PLACE (State or foreign country)

Chester, S.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Abe Dixon

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Alberta Thompson

18.

422.1

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED 9/23/65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

Sept 27/65

23C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cem

23D. LOCATION (City, town, or county) (State)

Westport Md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 27 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Milton E. Elickson 1129 N. Carroll St

ADDRESS

WALTER H. STODOLSKY

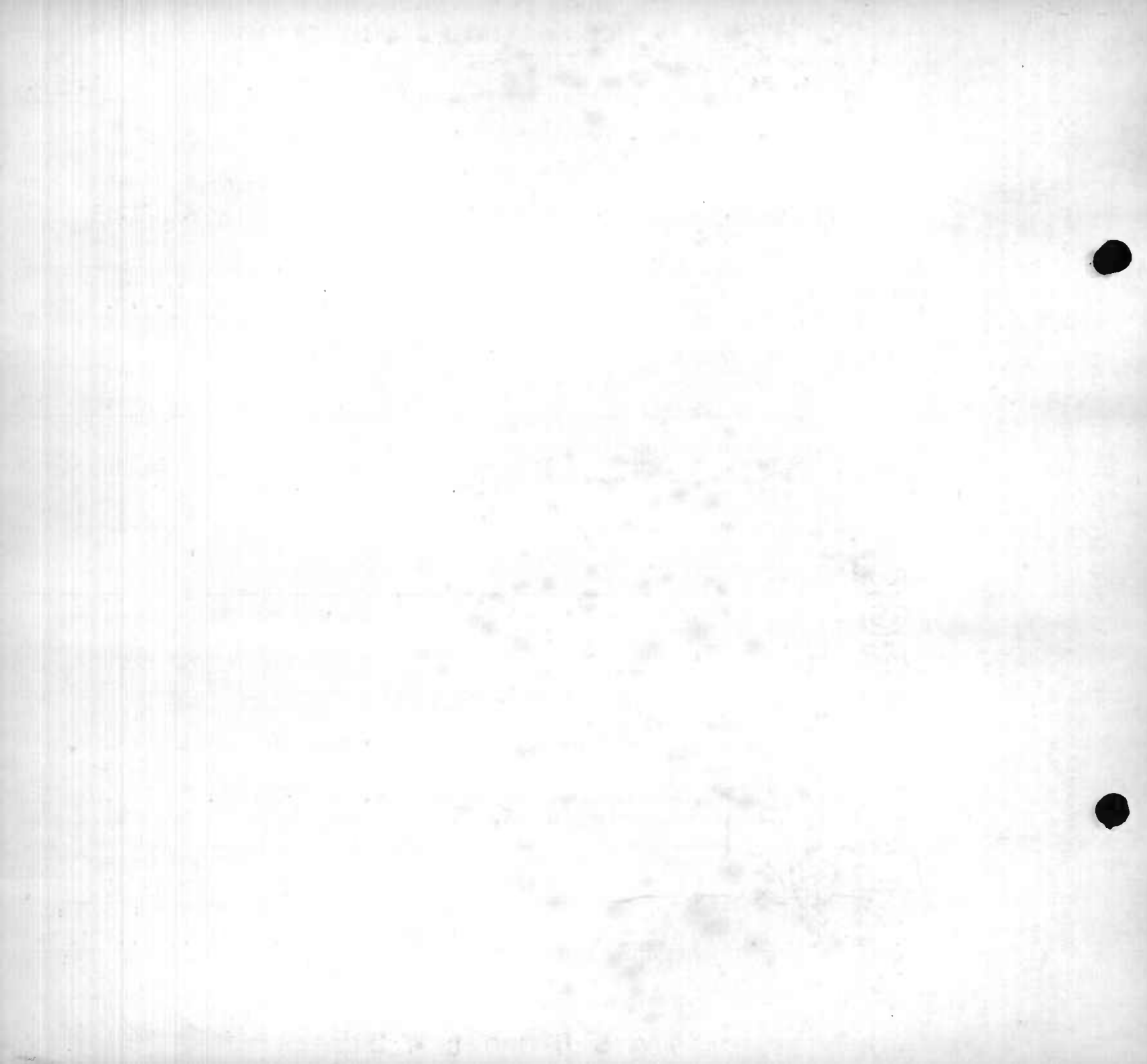
PROFESSOR

Classical

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

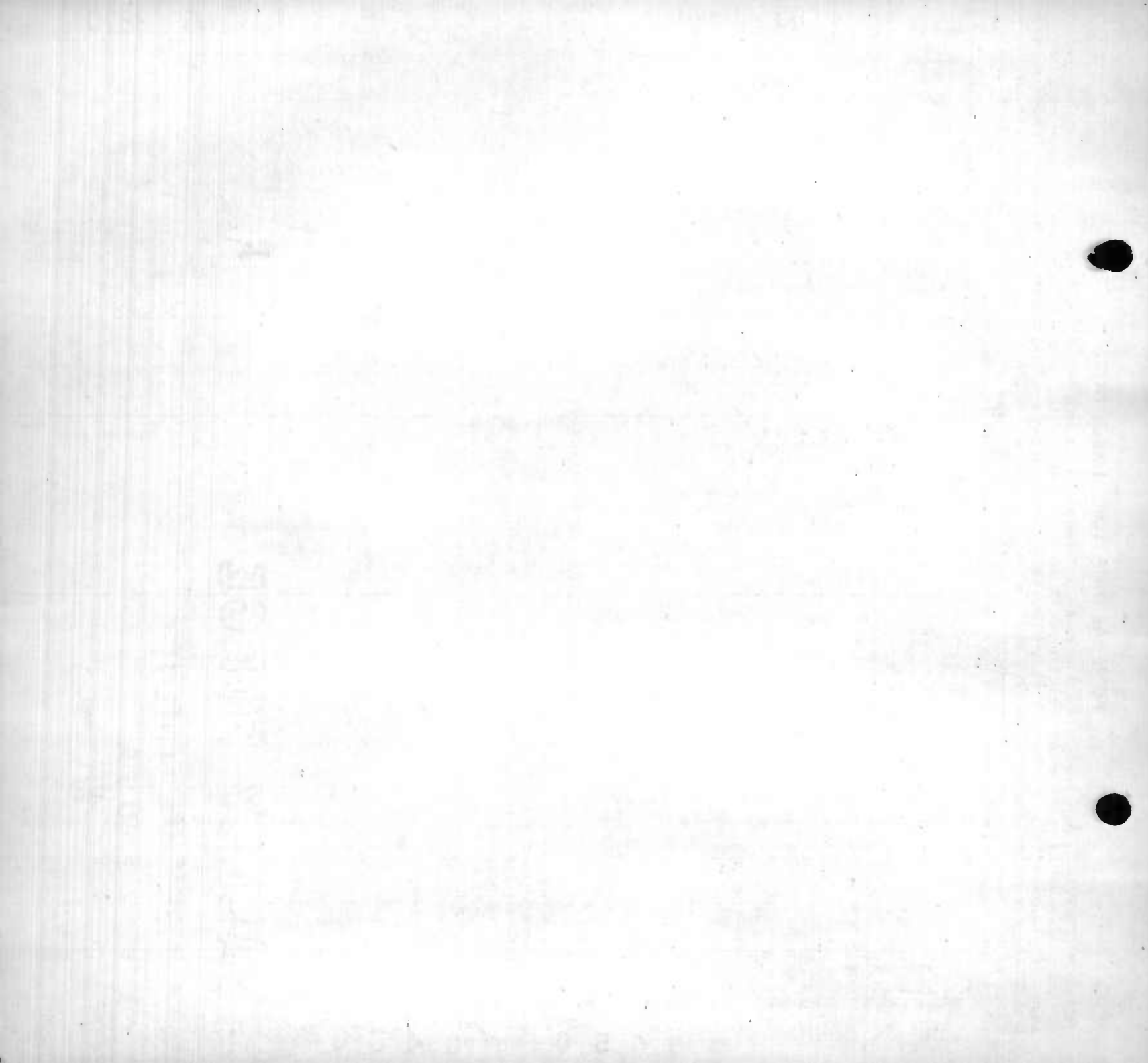
| BIRTH NO. 65 9869 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9869 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) Willie Hill | | | |
| 2. DATE AND HOUR OF DEATH September 25, 1965 12:45 A.M. | | | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 8-05 | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| D. STREET ADDRESS (If rural, give location) 1938 Washington Street, #21213 | | | | FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland, #21224 | | | |
| 5. SEX Male | | 6. RACE Negro | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Separated | | 8. DATE OF BIRTH Sept 19, 1928 | |
| 9. AGE (In years last birthday) 37 | | 10. UNDER 1 Yr. Months: Days: Hours: Min. | | 11. BIRTHPLACE (State or foreign country) South Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | |
| 13. FATHER'S NAME Benjamin Hill | | | | 14. MOTHER'S MAIDEN NAME Easter Foster | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes | | | | 16. SOCIAL SECURITY NO. 146X | | 17. INFORMANT RECORDS: BCH, 4940 Eastern Ave., #21224 | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Intercerebral Hemorrhage Malignant Hypertension INTERVAL BETWEEN ONSET AND DEATH 11 Hours ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from September 24, 1965 to September 25, 1965 , that (I) (we) last saw the deceased alive on September 25, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Leonard J. Quadracchi | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/25/65 | |
| 23C. PHYSICIAN'S NAME (Type) DR. LEONARD J. QUADRACCI | | | | 23D. ADDRESS 4940 Eastern Ave., Balto., Md., #21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Removal | | 24B. DATE 9/29/65 | | 24C. NAME of CEMETERY or CREMATORY Chester S.C. | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR Walter E. Elkins | | ADDRESS 1129 S. Cal. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

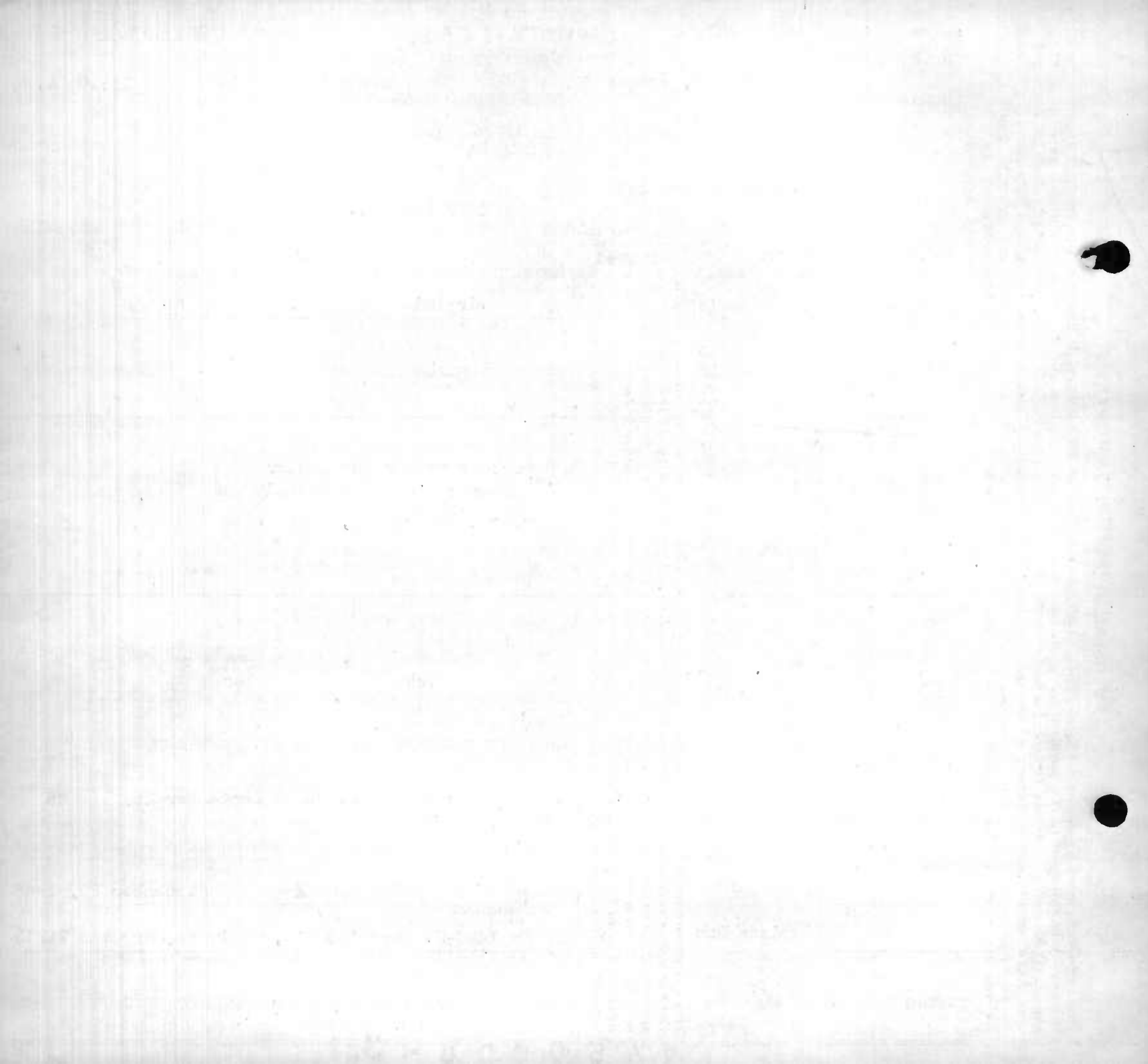
| | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|--------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------|----------------------------------------------|
| 65 9870 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9870 | |
| BIRTH NO. | | <h2 style="margin: 0;">CERTIFICATE OF DEATH</h2> | | DATE AND HOUR OF DEATH 9/24/65 10:30 P.M. | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| GARNER, CLARA | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| | | Md. | | Baito. | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore | |
| D. STREET ADDRESS (If rural, give location) | | 1818 Penrose Ave | | | |
| FRANKLIN Square Hospital | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| Female | Negro | Widow | 9-6-1898 | 67 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| None | | | | North Carolina | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| U.S.A. | | John McKeever | | Chloe | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | | | Sue Miller 1818 Penrose | |
| 18. 332 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) Cerebral artery thrombosis DUE TO | | 13 days | |
| | | (B) Uremia DUE TO | | prob. months | |
| | | (C) Generalized arteriosclerosis DUE TO | | prob. years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/11 19 65 to 9/24 19 65, that (I) (we) last saw the deceased alive on 9/24 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| R. M. Ayers | | | | 9/24/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Raimundo S. Magua | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Removal | | 9/18/65 | | McKEEVER FAMILY DUKELAND C.O.A.C. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| SEP 27 1965 | | Robert E. Taylor M.D. | | Thomas J. Ayers 638 N. Green St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

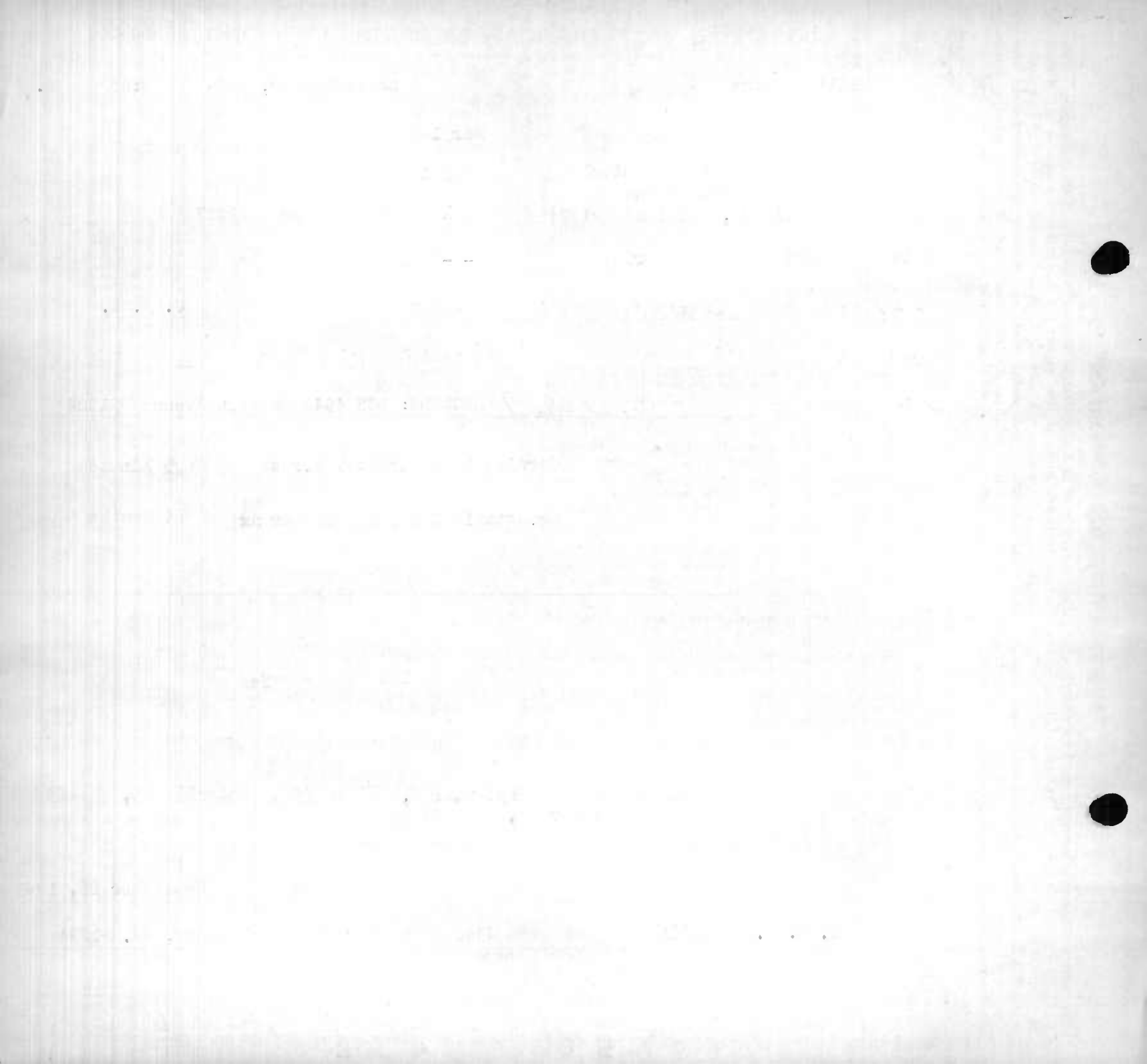
| BIRTH NO. 65 9871 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9871 | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|----------------------------------------------------------------------------------------------|---------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED (Type or Print) Mickens, Thomas E. | | | | 2. DATE AND HOUR OF DEATH September 25, 1965 11:10 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 9-09 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21202 D. STREET ADDRESS (If rural, give location) 1843 Hope St. | | | |
| 5. SEX Male | 6. RACE Colored | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH | 9. AGE (In years last birthday) 54 | If Under 1 Yr. Months: Days: | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY Steel | | 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John Mickens | | | 14. MOTHER'S MAIDEN NAME Queen Mitchell | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 228-05-9379 | | 17. INFORMANT John Mickens 3420 Piedmont Ave | | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) Hypertensive cardiovascular disease with cardiomegaly and infarction (B) Cerebral infarction, right side ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (C) | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| <div style="text-align: center;">II</div> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work At <input type="checkbox"/> Home | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from September 24, 1965 to September 25, 1965 , that (I) (we) last saw the deceased alive on September 25, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Govinda Rao | | | | 23B. DATE SIGNED September 25, 1965 | | | |
| 23C. PHYSICIAN'S NAME (Type) Govinda Rao | | | | 23D. ADDRESS 1400 N. Caroline St., Baltimore, Maryland 21213 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/25/65 | | 24C. NAME of CEMETERY or CREMATORY St. John's | | 24D. LOCATION (City, town, or county) (State) Baltimore | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | 25B. NAME OF REGISTRAR John E. Taylor | | 25C. FUNERAL DIRECTOR John E. Taylor 638 N. G. 2nd St. SE | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|-------------------------------------------------------------------|
| BIRTH NO. 65 9872 | | BALTIMORE CITY DEPARTMENT OF HEALTH | | Registered No. 65 9872 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) William Boone | | | 2. DATE AND HOUR OF DEATH September 25, 1965 6:45 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | 4. USUAL RESIDENCE (Where deceased lived) If institution; residence before admission) A. STATE Maryland B. COUNTY 16-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1612 Harlem Avenue 21217 | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 12-2-1911 | 9. AGE (In years last birthday) 53 | If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | | 10B. KIND OF BUSINESS OR INDUSTRY Super Food MKT | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Edward Boone | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 042-18 0987 | | 17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue 21224 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Cardiac & Respiratory Arrest DUE TO Metastatic Carcinoma of Larynx DUE TO INTERVAL BETWEEN ONSET AND DEATH 5 Minutes 4 Months | | | | | |
| 19. MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from September 8, 19 65 to September 25, 19 65 , that (I) (we) last saw the deceased alive on September 25, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Dr. M. E. Connolly | | | | 23B. DATE SIGNED September 25, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. M. E. Connolly | | 23D. ADDRESS 4940 Eastern Avenue Baltimore, Md. 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE SEP 27 1965 | | 24C. NAME of CEMETERY or CREMATORY Mount Carmel Cem | |
| 24D. LOCATION (City, town, or county) (State) Baltimore | | 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Farber M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Marshall P. Hays 138 N. B. in mcr st | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>65 9873</u> | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|---------------------------------------------------------------------------------|--------------------------------------------------------------|
| BIRTH NO. <u>2 65 9873</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>William M. Gaylor</u> | | 2. DATE AND HOUR OF DEATH <u>9/23/65</u> <u>6:45 PM</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| <div style="text-align: center;"> CERTIFICATE AMENDED <u>7/13/73</u> <u>UNION MEMORIAL HOSPITAL</u> </div> | | A. STATE <u>MARYLAND</u> | | B. COUNTY <u>25X04</u> | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE 25</u> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u> | | D. STREET ADDRESS (If rural, give location) <u>829 HERNDON</u> | | | |
| 5. SEX <u>M.</u> | 6. RACE <u>E. W.</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>3/9/93</u> | 9. AGE (In years last birthday) <u>72</u> | If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Clifton</u> | | 11. BIRTHPLACE (State or foreign country) <u>TENN.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>JOHN GAYLOR</u> | | 14. MOTHER'S MAIDEN NAME <u>ALMEDIA BAIRD (DEAD)</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u> | | 16. SOCIAL SECURITY NO. <u>415 10 8219</u> | | 17. INFORMANT <u>Mrs. Mattie Gaylor, 829 Herndon Court</u> | |
| 18. <u>332X1</u> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) DUE TO <u>Coronary Thrombosis</u> | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO <u>Atherosclerosis</u> | | | |
| (C) <u>PH</u> | | | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Sept 21</u> 19 <u>65</u> to <u>Sept 23</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Sept 23</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>[Signature]</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>9/23/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>DR. V. RODRIGUEZ</u> | | 23D. ADDRESS M.D. <u>UNION M. HOSPITAL</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u> | 24B. DATE <u>9/27/65</u> | 24C. NAME OF CEMETERY or CREMATORY <u>Meadowridge</u> | | 24D. LOCATION (City, town, or county) (State) <u>Dorsey, Howard Co., Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 27 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | 25C. FUNERAL DIRECTOR'S ADDRESS <u>Witzke F.D. 4101 Edmondson Ave.</u> | |

7/13/73 - Letter from Medical Record Dept., Union Memorial Hospital.
Mrs. Adeline Dorsey.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

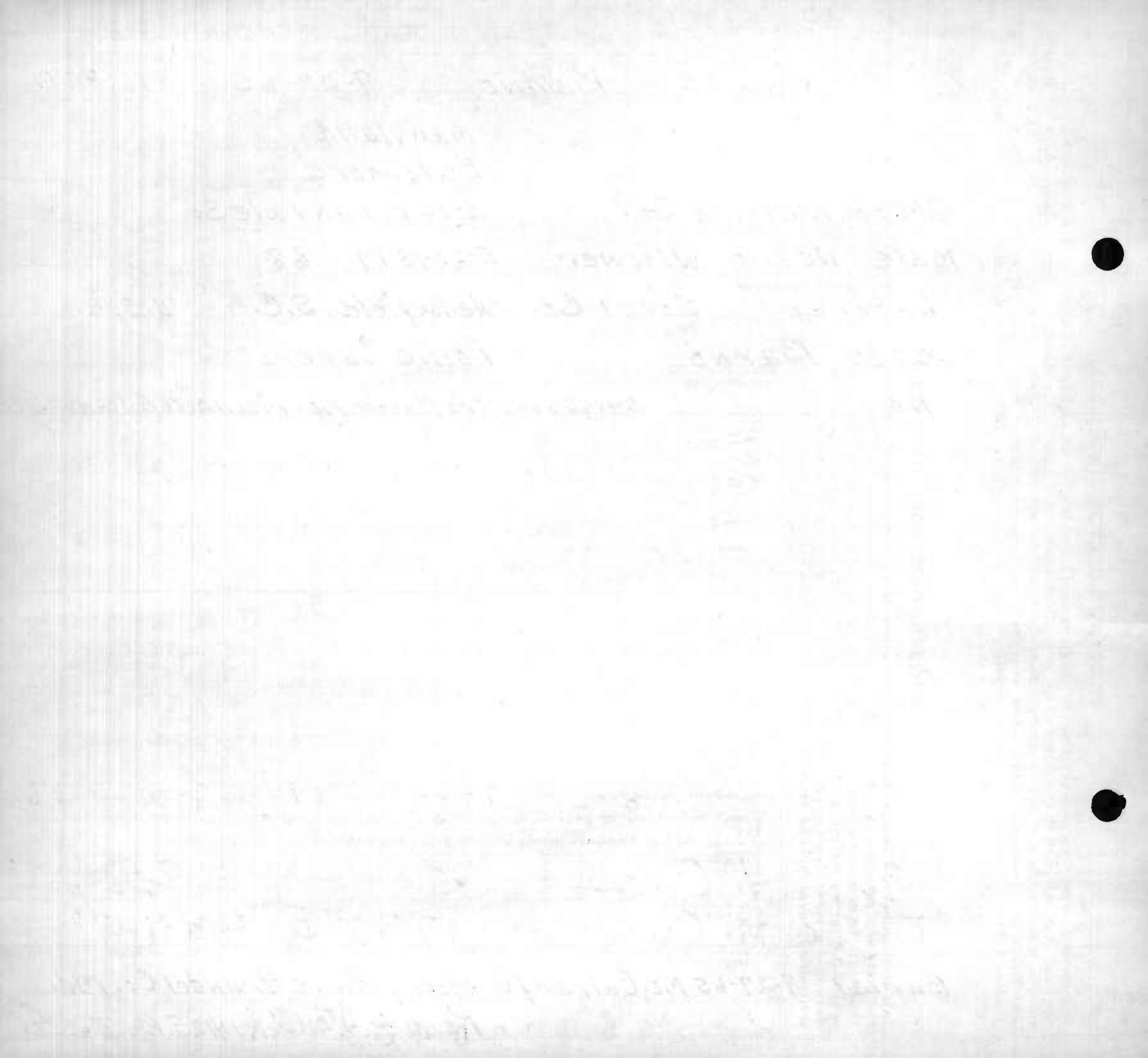
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9874 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------|-----------------------------------------------------------------------------|----------------------------------------------------------|
| BIRTH NO. 65 9874 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Colvin, Nettie | | 2. DATE AND HOUR OF DEATH September 21, 1965 11:45 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital | | A. STATE Maryland B. COUNTY 8-06 | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21213 | | | |
| | | D. STREET ADDRESS (If rural, give location) 1745 N. Castle St. | | | |
| 5. SEX Female | 6. RACE Colored | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 9-5-1915 | 9. AGE (In years last birthday) 50 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker | | 10B. KIND OF BUSINESS OR INDUSTRY OWN HOME | | 11. BIRTHPLACE (State or foreign country) South Carolina | |
| 13. FATHER'S NAME Jim Crowley | | 14. MOTHER'S MARDEN NAME Mary Hill | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 220-24-1414 | | 17. INFORMANT Sam Colvin 1745 N. Colvin St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) DIGITALIS TOXICITY | | CAUSE OF DEATH (A) Digitalis toxicity DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. DIABETES MELLITUS | | (B) Diabetes mellitus DUE TO | | | |
| (C) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from September 21, 1965 to September 21, 1965 , that (I) (we) last saw the deceased alive on September 21, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Jose D. Manalo M.D. | | | | 23B. DATE SIGNED September 21, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Jose D. Manalo, | | | | 23D. ADDRESS M.D. 1400 N. Caroline St., Baltimore, Maryland 21213 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-25-65 | | 24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Anne Arundel Co. Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | 25B. NAME OF REGISTRAR Randolph J. Collick | |
| 25C. FUNERAL DIRECTOR ADDRESS 1412 E. Preator St. | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9875 | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|--------------------------------------------------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. M.E. CASE NO. | | CERTIFICATE OF DEATH | | 65 9875 | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| James Barrio | | 9-22-65 10:45 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| | | A. STATE B. COUNTY | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | Maryland 8-06 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 2006 E. Lanvale St. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| Male | Negro | Widower | 5-23-1897 | 68 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? |
| Laborer | | Steel Co. | Wedgefield, S.C. | | U.S.A. |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Mose Barrio | | | Pollie Capers | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| NO | | 241-12-8880 | Mrs. Hattie Morrison 2006 E. Lanvale St. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 177X I | | Prostatic Carcinoma | | 4 Years | |
| ANTECEDENT CAUSES | | (A) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| | | (C) DUE TO | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7-25-1958 to 9-22-1965 that (I) (we) last saw the deceased alive on 9-21-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Eugene H. Owens M.D. | | | | 9-25-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Eugene H. Owens M.D. | | 1735 E Federal- | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | 9-27-65 | Mt. Calvary Cemetery | | Anne Arundel Co. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| SEP 27 1965 | | Robert E. Taylor | | Randolph Collick 142 E. Preston St. | |



Released on approval of medical examiner. Page 360

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. 65 9876 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9876 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) RIDER RAYMOND A. | | 2. DATE AND HOUR OF DEATH SEPT 25 10 45 PM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 15-12 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3408 Park Hts Ave. 15 | | M. | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER-MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 6/7/03 | 9. AGE (In years lost birthday) 62 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer | | 10B. KIND OF BUSINESS OR INDUSTRY Construction | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Joseph Rider | | 14. MOTHER'S MAIDEN NAME Sarah Chenoweth | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None | | 16. SOCIAL SECURITY NO. 218-01-0338 | | 17. INFORMANT Mrs. Sara Rathel Baltimore, Md. 6 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Ca of lung = metastatic malignant coxeris | | CAUSE OF DEATH Ca of lung = metastatic malignant coxeris | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | MEDICAL CERTIFICATION | | | |
| 19A. DATE OF OPERATION 9/1/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED fr femur | | 20A. AUTOPSY? (Yes or No) No No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Baltimore | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 6/30/65 | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? Fell down at home | | 22. I certify that (I) (this hospital) attended the deceased from 8/30/19 65 to 9/25/19 65, that (I) (we) last saw the deceased alive on 9/25/19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Dinesh Patel | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/> Resident | | 23B. DATE SIGNED 9/25/65 | |
| 23C. PHYSICIAN'S NAME (Type) DINESH PATEL | | M.D. | | 23D. ADDRESS Sinai Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/29/1965 | | 24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery | |
| 24D. LOCATION (City, town, or county) Woodlawn, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR Wm. J. Zingales | | 25D. ADDRESS Baltimore, Md. 17 | | | |

CT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|--------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. 65 9877 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9877 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Cecilia H. Seifert | | 9-24-65 | | 12:55 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| South Baltimore General Hosp. | | Maryland | | Anne Arundel | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Brooklyn #21225 | |
| | | D. STREET ADDRESS (If rural, give location) | | 211 W. Meadow Rd. | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| F | White | Widow | Dec. 1, 1906 | 58 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Housewife | | | | Md. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Joseph Klappenberger | | Cora Listering | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | None | | 211 W. Meadow Rd. | |
| | | | | Mrs. Cecilia Keene Brooklyn, Md. 25 | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 581.0 I | | Hepatic Coma | | | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | Cirrhosis - complication of Gastrointestinal Hemorrhage. | | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (this hospital) attended the deceased from | | 9-23 1965 to | | 9-24 1965 | |
| that (we) last saw the deceased alive on | | 9-24 1965 | | and that in (our) opinion death occurred on the date | |
| and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| K. Bonovich | | | | 9-24-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| | | M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 9/27/1965 | | Loudon Park Cemetery | |
| | | | | Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| SEP 27 1965 | | Robert E. Fairbank | | Wm. J. Tipton | |
| | | | | Baltimore, Md. 21217 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9878 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9878 | |
| M.E. CASE NO. | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) SNYDER, EMMA AUGUSTA | | | 2. DATE AND HOUR OF DEATH 9/26/65 9 18 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL | | | A. STATE MARYLAND B. COUNTY Baltimore | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) Towson | | | D. STREET ADDRESS (If rural, give location) 311 OVERBROOK Rd 12 | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 8/3/95 | 9. AGE (In years last birthday) 70 | 10. If Under 1 Tr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S. |
| 13. FATHER'S NAME JOHN LESNER | | | 14. MOTHER'S MAIDEN NAME MARGARET WOLFE | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None | | 16. SOCIAL SECURITY NO. 215-05-2713 D | 17. INFORMANT ADDRESS MRS. WM STANSBURY 135 STEVENSON LA | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES | | | (A) DIABETES MELLITUS DUE TO | | 10 YRS |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) CORONARY ARTERY DISEASE DUE TO | | 2 YRS |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | (C) Myocardial infarction, diffuse, old | | |
| 19A. DATE OF OPERATION 3/14/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED GANGRENE OF LEG | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 4/5 |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/21 1965 to 9/26 1965, that (I) (we) last saw the deceased alive on 9/26 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Charles S. Brown | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/26/65 |
| 23C. PHYSICIAN'S NAME (Type) DR. CHARLES S. BROWN | | | 23D. ADDRESS M.D. UNION MEMORIAL HOSPITAL | | |
| 24A. BURIAL REMOVAL (Specify) Burial | | 24B. DATE 9/29/1965 | 24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery | | 24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR Wm. J. Tschern & Sons Baltimore, Md. 17 North Pa. Ave. | |

THE UNIVERSITY OF CHICAGO
LIBRARY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9879 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9879 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) BEERS, BABY BOY | | | 2. DATE AND HOUR OF DEATH 9-23-65 2:45 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME & HOSPITAL BALTIMORE, MD. | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY U.S.A. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1129 HEWITT WAY | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) - | 8. DATE OF BIRTH 9-22-65 | 9. AGE (In years last birthday) 4 | If Under 1 Yr. Months: Days: Hours: Min. 4 50 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) USA, MD. | |
| 13. FATHER'S NAME EDWARD BEERS | | | 14. MOTHER'S MAIDEN NAME MARY BRACEY | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. 763.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Respiratory Failure DUE TO Bi-lateral Congestive Pulmonary Consolidation and atelectasis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Patent Ductus Arteriosus | | | INTERVAL BETWEEN ONSET AND DEATH 4 hrs 50 mins | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION D | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>[Signature]</i> M.D. | | | | 23B. DATE SIGNED | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| 24D. LOCATION (City, town, or county) | | 24E. STATE | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | 25B. NAME OF REGISTRAR <i>[Signature]</i> | | 25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD | |
| 25D. ADDRESS | | | | | |

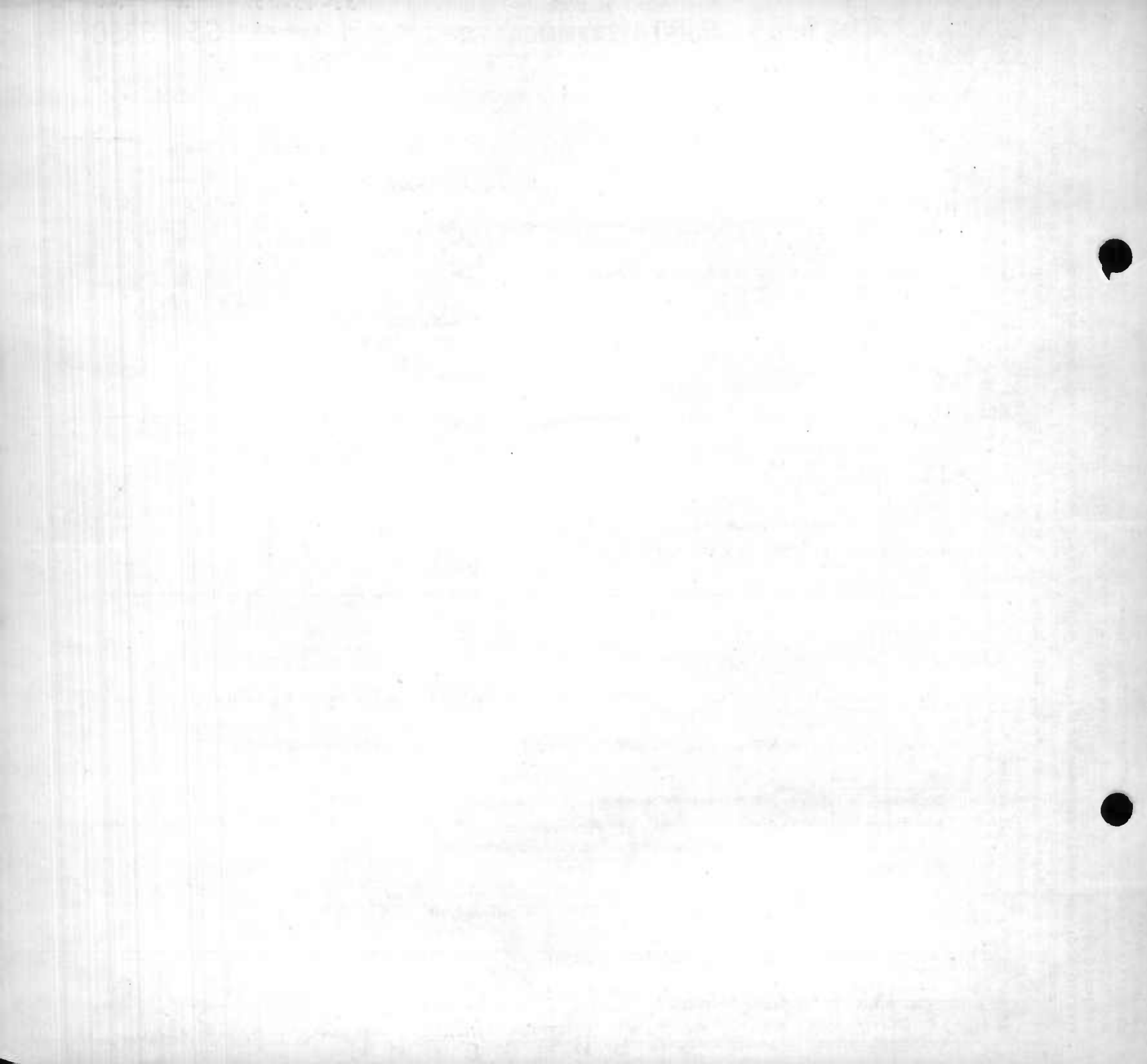
John Brown

John Brown

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. <u>65-18799</u> <u>65</u> <u>9880</u> | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. <u>65-43-25</u> <u>3880</u> | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Sonia Maria Thomas</u> | | 2. DATE AND HOUR OF DEATH <u>9-20-65</u> <u>12:20 P.</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION <u>38 UNIVERSITY HOSPITAL</u> | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Pr. Geo.</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Conway Road, Murrink Md.</u> D. STREET ADDRESS (If rural, give location) <u>Conway Rd. Murrink Ind</u> | | | |
| 5. SEX <u>Female</u> | 6. RACE <u>Negro</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH <u>8-1-65</u> | 9. AGE (In years lost birthday) <u>6 wks.</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 13. FATHER'S NAME <u>Joseph A. Thomas</u> | | 14. MOTHER'S MAIDEN NAME <u>Seen Thomas</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, No or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 18. <u>053.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO <u>Hypertonic Dehydration</u> (B) DUE TO <u>? Septicemia</u> (C) <u>Peripheral Circ. Failure</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u> <u>few min.</u> | |
| MEDICAL CERTIFICATION | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>2</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>Yes</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Sept. 20</u> 19 <u>65</u> to <u>Sept 20</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>Sept. 20</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>G. Hyman</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>9-20-65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>GRACE AY4 YAO</u> | | 23D. ADDRESS <u>Univ. Hospital</u> | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>9-24-65</u> | | 24B. DATE <u>9-24-65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Queens Chapel</u> | |
| 24D. LOCATION <u>Murrink Md</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 27 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Johnson</u> | | 25C. FUNERAL DIRECTOR <u>W.S. Washington & Sons 4925 Deane Ave N.E.</u> | |



FUNERAL DIRECTOR: IMPORTANT

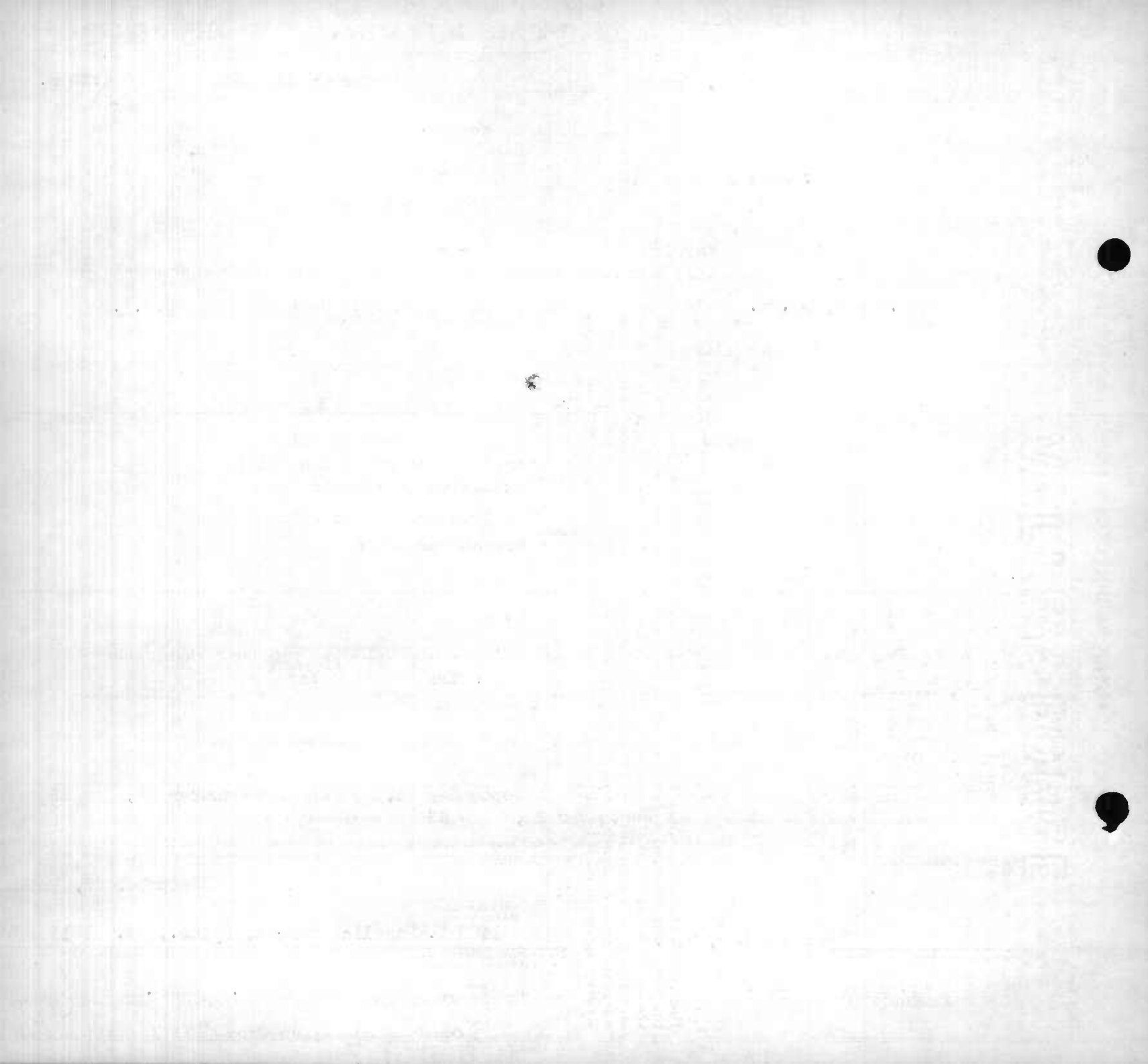
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 3881 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9881 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------------------------|-----------------|----------------------------------------------------------------------|-------|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| | | | | GORMAN, MRS MARY O'CONNELL | | Sept. 23, 1965 3:20 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| JENKINS MEMORIAL HOSPITAL 1000 S CATON AVENUE BALTIMORE, MD 21229 | | | | MARYLAND 27-13 | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | BALTIMORE 21210 | | | |
| D. STREET ADDRESS (If rural, give location) | | | | 804 W. Belvedere Ave. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED | 8. DATE OF BIRTH | 9. AGE (In years) | 10. UNDER 1 Yr. | 10. UNDER 24 Hrs. | |
| Female | White | WIDOWED, DIVORCED (specify) | 12/26/1886 | 78 | Months | Days | Hours |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Housewife | | Homemaker | | Co Mayo, Ireland | | U S A | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| JAMES O'CONNELL | | | | Anne Kearns | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| | | | | | | 804 W. BELVEDERE AVE. Mrs. Jos. E. Muse Jr. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) | | | | (A) DUE TO | | Acute myocardial infarction 12 hrs | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | Arteriosclerotic heart disease 9 years | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) | | | |
| II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | cancer widespread? source | | 9 months | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (X) (this hospital) attended the deceased from June 11 1965 to Sept 23 1965, that (X) (we) lost saw the deceased alive on 9/23/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| J. Raymond Gladue M.D. | | | | 8/23/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| J RAYMOND GLADUE M.D. | | | | JENKINS MEMORIAL HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| BURIAL | | 9/25/65 | | CATHEDRAL | | BALTIMORE, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| SEP 27 1965 | | Robert E. Taylor | | H.W. MEARS & SON | | 805 N. CALVERT ST. | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|-----------------------------------------------------------------------------|----------------------------------------|--|
| 65 9882 | | | | | CERTIFICATE OF DEATH | | | | |
| BIRTH NO. | | | | | Registered No. 65 9882 | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | | 2. DATE AND HOUR OF DEATH | | | | |
| Pilarski, Frank | | | | | September 24, 1965 4:30 p.m. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph Hospital | | | | | A. STATE Maryland | | | | |
| | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | | |
| D. STREET ADDRESS (If rural, give location) 7911 Belair Road #36 | | | | | B. COUNTY Balto | | | | |
| | | | | | | | | | |
| 5. SEX 53 M | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH 10-3-1911 | 9. AGE (In years lost birthday) 53 | 10. If Under 1 Yr. Months: Days: Hours: Min. | | 11. If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) Beth. Steel, Sp. Pt. | | | 10B. KIND OF BUSINESS OR INDUSTRY Electric Welder | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Andrew Pilarski | | | | | 14. MOTHER'S MAIDEN NAME Mary Wagner | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 213- 07- 9260 | | 17. INFORMANT Mrs Mildred Pilarski 7911 Belair Road | | | | |
| 18. CAUSE OF DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (A) Carcinoma of right lung with extensive metastasis | | | | |
| | | | | | (B) Purulent bronchitis with bronchopneumonia | | | | |
| | | | | | (C) | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from September 21, 1965 to September 24, 1965, that (I) (we) last saw the deceased alive on September 24, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Govinda Rao, M.D. | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | 23B. DATE SIGNED September 25, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Govinda Rao, M.D. | | | | | 23D. ADDRESS M.D. 1400 N. Caroline Street, Balto., Md. 21213 | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-28-1965 | | 24C. NAME OF CEMETERY or CREMATORY St Joseph's Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore Co. Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | 25B. NAME OF REGISTRAR Robert E. Fisher M.D. | | | 25C. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road | | | | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
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| 65 9883 | | | | | 65 9883 | | | | |
| BIRTH NO. | | | | | Registered No. | | | | |
| M.E. CASE NO. | | | | | CERTIFICATE OF DEATH | | | | |
| 1. NAME OF DECEASED (Type or Print) LEONA B. ESPOSITE | | | | | 2. DATE AND HOUR OF DEATH Sept-23-65- 10:20 A.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 35 Church Home and Hospital | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 26-05 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 817 S. Tolna St. #24 | | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH 3-6-17 | 9. AGE (In years last birthday) 48 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME John Mangum | | | | | 14. MOTHER'S MAIDEN NAME Beatrice Brooks | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT WILLIAM M. ESPOSITE | | ADDRESS SAME | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 152.7 I Metastatic Argentaaffin tumor of Jejunum - Brain Anoxia | | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO Cardiac Arrest | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II Electrolyte Imbalance | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION Sept 13/65 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Repair Ventral Hernia | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 12 1965 to Sept 23 1965 , that (I) (we) last saw the deceased alive on Sept 23 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE William Garlick M.D. | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Sept 23/65 | | |
| 23C. PHYSICIAN'S NAME (Type) William Garlick | | | | | 23D. ADDRESS 1866 Circle Rd. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-27-65 | | 24C. NAME of CEMETERY or CREMATORY BALTIMORE NATIONAL CEM | | 24D. LOCATION (City, town, or county) (State) 5501 FREDERICK AVE. BALTO., MD. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | | 25B. NAME OF REGISTRAR Robert E. Fisher | | 25C. FUNERAL DIRECTOR Charles J. Siller ADDRESS 6224 EASTERN AVE. BALTO., MD. | | | | |

Glenn H. H. H. H.

812 2 1000 1000

3-0-17 1000 1000 1000

Boatman (Boat) 1000 1000 1000

Statistical Department
Tune of Virginia
Caroline (Caroline)

Statistical Department

Sept 1917 1000 1000 1000

Sept 1917 1000 1000 1000

William C. C. C.

1866 1000 1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9884 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9884 | |
| M.E. CASE NO. | | | 2. DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) JOHN ALBERT MATTHEWS | | | SEPTEMBER 22 1965 5:01 P M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| CERTIFICATE AMENDED | | | A. STATE MARYLAND | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | |
| 40 | | | D. STREET ADDRESS (If rural, give location) 4500 F DUNLAND ROAD | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH NOV 28 1913 | 9. AGE (In years last birthday) 51 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EXECUTIVE | | 10B. KIND OF BUSINESS OR INDUSTRY MARYLAND DELIVERIES | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? UNITED STATES | | | 13. FATHER'S NAME Matthews | | |
| 14. MOTHER'S MAIDEN NAME Elsie | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII | | |
| 16. SOCIAL SECURITY NO. 213 10 4943 | | 17. INFORMANT AVENUE ST. AGNES RECORDS WILKINS AND CATON | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH About 10 hrs. | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) DUE TO Admission to hospital with infection (pneumonia) | | |
| (B) DUE TO | | | (C) DUE TO | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from SEPTEMBER 22 1965 to SEPTEMBER 22 1965 , that (X) (we) last saw the deceased alive on SEPTEMBER 22 1965 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Jeannette R. Heginian, M.D.</i> | | | 23B. DATE SIGNED September 22, 1965 | | 23C. PHYSICIAN'S NAME (Type) JEANNETTE HEGINIAN M.D. |
| 23D. ADDRESS 2212 South Road, Balto, Md. | | | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | |
| 24B. DATE 9/27/65 | | 24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | 25B. NAME OF REGISTRAR <i>Robert E. Farber, M.D.</i> | | 25C. FUNERAL DIRECTOR ADDRESS Hubbard Funeral Home 4107 Wilkens Ave. 21229 | |

St. Agnes Hospital

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------|--|
| BIRTH NO. 65 9885 | | <div>CERTIFICATE OF DEATH</div> <div>Registered No. 65 9885</div> | | | | | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MRS. RUTH M. McKIBBIN | | | | 2. DATE AND HOUR OF DEATH SEPTEMBER 23, 1965 6:00 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 91 MONTEBELLO STATE HOSPITAL | | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MARYLAND C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 5538 OLD LAWYERS HILL ROAD | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED | | 8. DATE OF BIRTH 3/17/11 | 9. AGE (In years, lost birthday) 54 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICE CLERK | | 10B. KIND OF BUSINESS OR INDUSTRY NOT KNOWN | | 11. BIRTHPLACE (State or foreign country) PENNSYLVANIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME ALFRED T. WINTER | | | | 14. MOTHER'S MAIDEN NAME AGNES EWING | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NOT KNOWN | | | | 16. SOCIAL SECURITY NO. 208-26-3606 | | 17. INFORMANT ADDRESS HOSPITAL CHART | | | |
| 18. 345X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) MULTIPLE SCLEROSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | INTERVAL BETWEEN ONSET AND DEATH ABOUT 5 yrs. | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 10 / 5 19 64 to 9 / 23 19 65 , that (I) (we) last saw the deceased alive on 9 / 22 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Reuben C. Guerrero M.D. | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/23/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) REUBEN C. GUERRERO M.D. | | | | 23D. ADDRESS MONTEBELLO STATE HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/27/65 | | 24C. NAME of CEMETERY or CREMATORY Meadowridge | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | 25B. NAME OF REGISTRAR Robert E. Fisher | | 25C. FUNERAL DIRECTOR ADDRESS Hubbard Funeral Home 4107 Wilkens Ave. 21229 | | | | | |

Robert C. McNamee

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9886 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------|--------------------------------------------------------------------------|------------------------------------------|
| BIRTH NO. 65 9886 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Otto A Geumann | | 2. DATE AND HOUR OF DEATH 9-26-65 6:25 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Mercy Hospital | | A. STATE Maryland B. COUNTY Baltimore | | | |
| CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | D. STREET ADDRESS (If rural, give location) 2711 Fenwick Ave. FENWICK AVENUE | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 3/12/1885 | 9. AGE (In years last birthday) 80 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Draftsman (Ret.) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Johannes Heinrich Geumann | | 14. MOTHER'S MAIDEN NAME Louise Lamsbach LAMSBACH | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Mrs. Alice M. Geumann 6607 GlenOak Ave. #14 | |
| 18. 422.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cardiac Failure | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH 1 mos | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) Dehydration + Salt depletion DUE TO | | 1 mos | |
| | | (C) ASCVD DUE TO | | 15 yrs | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION NONE | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 9-4-65 to 9-26-65 , that (1) (we) last saw the deceased alive on 9-26-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Werner Beck | | | | 23B. DATE SIGNED 9-26-65 | |
| 23C. PHYSICIAN'S NAME (Type) Werner Beck | | | | 23D. ADDRESS Mercy Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/29/65 | | 24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore Co., Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Farley M.D. | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd. #14 | | | |

vs 153 signed by licensed funeral director. 9/28/65 C. P. Bowens

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. | | 65 9887 | | CERTIFICATE OF DEATH | | Registered No. 5 9887 | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------|--|--|
| 1. NAME OF DECEASED (Type or Print) | | | | Mary Ann Waltman | | | | 2. DATE AND HOUR OF DEATH Sept. 25, 1965 10 a.m. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Maryland Baltimore City 27-34 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5858 Belair Rd. | | | | |
| 5. SEX F. | | 6. RACE W. | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH 10/31/05 | | 9. AGE (In years lost birthday) 59 | | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beautician | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) Crewe, Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME William D. Stultz | | | | 14. MOTHER'S MAIDEN NAME Minnie XXXXXXX F. Cble | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | | 16. SOCIAL SECURITY NO. 215-10-8925 | | 17. INFORMANT Mr. Harry L. Waltman & Hospital chart | | | | ADDRESS Same | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 443X I CAUSE OF DEATH (A) Cerebral hemorrhage DUE TO (B) Hypertensive cardio-vascular disease. About 20 years DUE TO (C) Unknown cause. INTERVAL BETWEEN ONSET AND DEATH 3-5 minutes | | | | 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. None. | | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ----- | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) Not applicable | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Not applicable | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Not applicable | | | | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) Not applicable | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Not applicable | | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from July 22, 1965 to Sept. 25, 1965, that (I) (we) last saw the deceased alive on Sept. 25, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 23A. SIGNATURE Cesar J. Pellerano | | | | | | | | 23B. DATE SIGNED Sept. 25, 1965. | | | | |
| 23C. PHYSICIAN'S NAME (Type) Cesar J. Pellerano, M.D. | | | | 23D. ADDRESS Montebello State Hospital | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/29/65 | | 24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery | | | | 24D. LOCATION (City, town, or county) (State) Baltimore Co., Maryland | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | | | 25B. NAME OF REGISTRAR Robert E. Farber, M.D. | | | | 25C. FUNERAL DIRECTOR ADDRESS Leonard J. Rack Inc., 5305 Harford Rd. #14 | | | | |

also, quantity

number, year

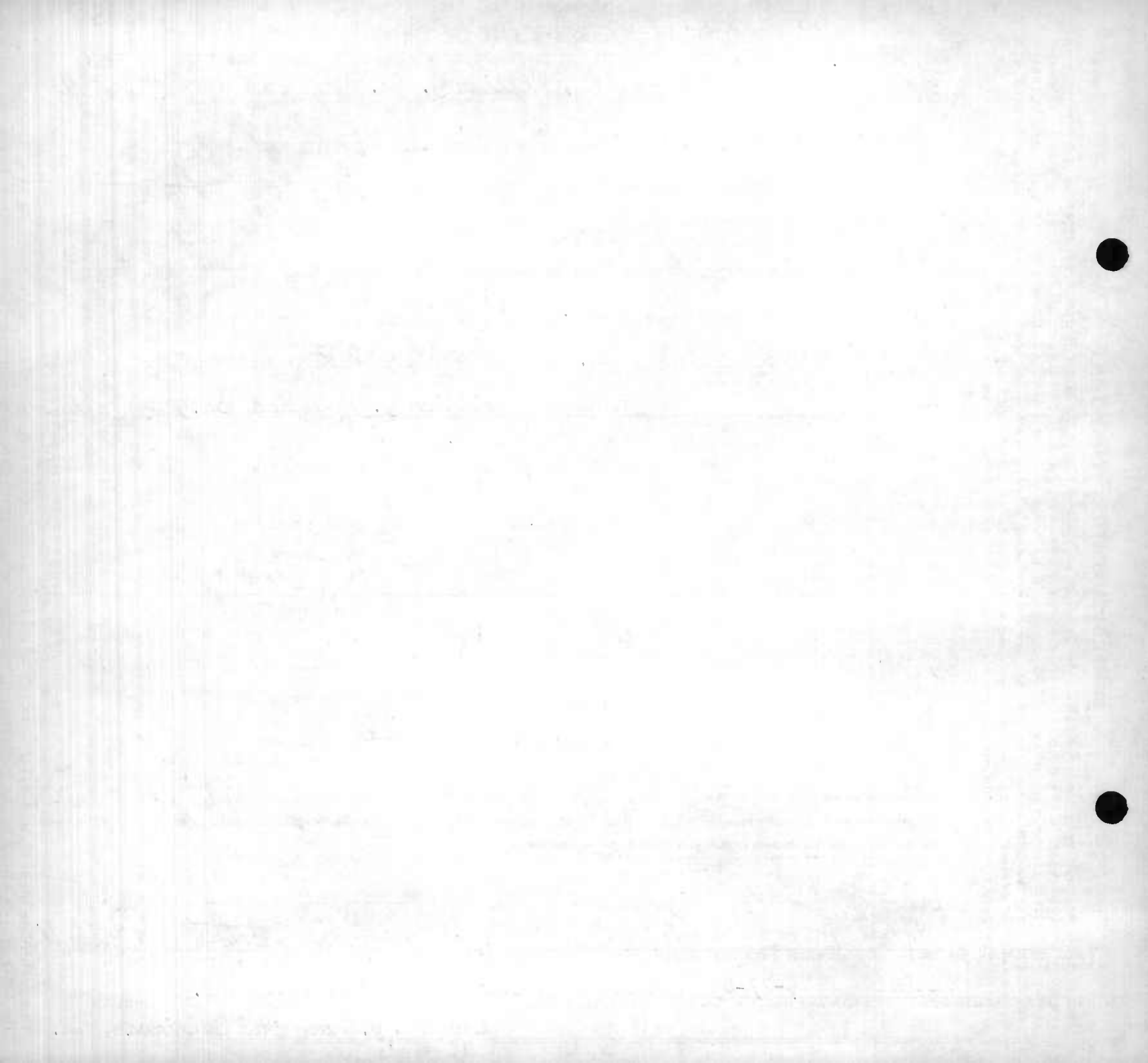
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 9888 | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|
| CERTIFICATE OF DEATH | | | | | |
| BIRTH NO. 40-22440 65 9888 | | | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Baby Boy P. FLUGRAD, William G. Jr.</u> | | 2. DATE AND HOUR OF DEATH <u>9/26/65 4:00 PM</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| <u>PRC HOSPITAL</u> <small>(If not in hospital, institution, give street address or location)</small> | | <u>5205 Eastbury</u> <small>A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u></small> <small>C. CITY OR TOWN <u>Baltimore</u> (If outside city limits, give township)</small> | | | |
| 5. SEX <u>Male</u> | | 6. RACE <u>White</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Child</u> | |
| 8. DATE OF BIRTH <u>9/23/65</u> | | 9. AGE (In years last birthday) <u>3</u> | | If Under 1 Yr. Months: <u>3</u> Days: <u>3</u> Hours: <u>3</u> Min. <u>3</u> | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Balto, Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Wm G. PFLUGRAD, Sr.</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Barbara L. Santmyer</u> | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | | |
| 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT <u>William G. Pflugrad, Sr.</u> ADDRESS <u>5205 Eastbury</u> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| <u>762.51</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO <u>Central Nervous System Bleeding</u> (B) DUE TO <u>Central NS - anoxic</u> (C) <u>Prematurity (comp. gestation)</u> | | <u>18 hours</u> | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Hypertension</u> | | | | | |
| 19A. DATE OF OPERATION <u>none</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) <u>Sept 23 1965</u> | | White <input type="checkbox"/> Not White <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/> | | | |
| 22. I certify that (this hospital) attended the deceased from <u>Sept 23 1965</u> to <u>Sept 26 1965</u> , that (I/we) last saw the deceased alive on <u>Sept 26 1965</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Wm E. Schwartz</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>9/26/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Wm E. Schwartz</u> | | 23D. ADDRESS <u>Mercy Hospital Balto Md.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u> | | 24B. DATE <u>9-27-65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Woodlawn Cemetery</u> | |
| 24D. LOCATION (City, town, or county) <u>Baltimore, Md.</u> | | 24E. STATE (State) <u>MD.</u> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 27 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Faldut</u> | | 25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc</u> ADDRESS <u>Baltimore, Md.</u> | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9889 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. 65 9889 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | | DATE AND HOUR OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) CONITS, KATHERINE G. | | | 9/26/65 C 30 M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL | | | A. STATE MARYLAND B. COUNTY 27-48 | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | |
| | | | D. STREET ADDRESS (If rural, give location) 6101 YORK Rd. | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 3/17/95 | 9. AGE (In years last birthday) 70 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (State or foreign country) GREECE | | 12. CITIZEN OF WHAT COUNTRY? GREECE |
| 13. FATHER'S NAME Crist Tzanetakos | | | 14. MOTHER'S MAIDEN NAME Mary ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. GEN CITY 218-32-4788 | | 17. INFORMANT CHRIST CONITS (SON) | |
| | | | | ADDRESS SAME | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) AC MYOCARDIAL INFARCT | | | INTERVAL BETWEEN ONSET AND DEATH 8/29 - 9/27 | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (A) DUE TO (B) DUE TO (C) DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/29 19 65 to 9/26 19 65 , that (I) (we) last saw the deceased alive on 9/26 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Charles S. Brown | | | | 23B. DATE SIGNED 9/26/65 | |
| 23C. PHYSICIAN'S NAME (Type) DR CHARLES S BROWN | | | | 23D. ADDRESS UNION MEMORIAL HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/29/65 | | 24C. NAME OF CEMETERY or CREMATORY Greek Orthodox Cemetery | |
| | | | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | 25B. NAME OF REGISTRAR Robert E. Tolson | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc., 5305 Harford Rd. #14 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9890 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9890 | |
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| 1. NAME OF DECEASED (Type or Print) <i>Clinton Edward Senft</i> | | | | 2. DATE AND HOUR OF DEATH <i>Sept. 27, 1965 13:30 P M.</i> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>6305 Laurelton Ave.</i> | | | | A. STATE <i>Md.</i> B. COUNTY <i>27-07</i> | | | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | | |
| D. STREET ADDRESS (If rural, give location) <i>6305 Laurelton Ave.</i> | | | | | | | |
| 5. SEX <i>male</i> | 6. RACE <i>white</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i> | 8. DATE OF BIRTH <i>6-26-1913</i> | 9. AGE (In years last birthday) <i>52</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Manager</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Paint Store</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Clifton E. Senft</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Elizabeth Conner</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>216-05-7496</i> | | 17. INFORMANT <i>Evelyn B. Senft</i> | | ADDRESS <i>same</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>420.11</i> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH (A) <i>Acute Coronary Insufficiency</i> DUE TO (B) <i>Coronary Sclerosis</i> DUE TO (C) <i>1 hour</i> <i>6 months</i> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1938</i> to <i>9-27-45</i> 19 that (I) (we) last saw the deceased alive on <i>9-25-45</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>E. W. Peake</i> | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>9/27/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>E. W. PEAKE</i> | | | | 23D. ADDRESS M.D. <i>4508 Harford Road Balto. 14 Md</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i> | | 24B. DATE <i>9/30/65</i> | | 24C. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem. Park</i> | | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 27 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Johnson</i> | | 25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc Baltimore, Md.</i> | | ADDRESS | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9891 | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|-------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| BIRTH NO. | | 65 9891 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) DONALD H. GOLDSBOROUGH | | 2. DATE AND HOUR OF DEATH SEPTEMBER 24, 1965 1:55 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, MARYLAND | |
| FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME AND HOSPITAL | | 6. STREET ADDRESS (If rural, give location) 432 ROSEBANK, AVE. | | | |
| 5. SEX MALE | 6. RACE CAUS. | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) DIVORCED | 8. DATE OF BIRTH AUG. 8, 1901 | 9. AGE (In years last birthday) 64 | 10. If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER | | 10B. KIND OF BUSINESS OR INDUSTRY GOV'T. | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME ARTHUR H. GOLDSBOROUGH | | 14. MOTHER'S MAIDEN NAME ROSE GUNTHER | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No. | | 16. SOCIAL SECURITY NO. 214-40-0600 | | 17. INFORMANT RICHARD H. GOLDSBOROUGH | |
| | | | | ADDRESS 6412 PINEHURST RD. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) 3-78X1 | | CAUSE OF DEATH (A) Acute Pulm. edema with DUE TO (B) Cong. Heart failure DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Acute Generalized Peritonitis | | | |
| 19A. DATE OF OPERATION 9/17/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Int. Bleeding | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/16 19 65 to 9/24 19 65 , that (I) (we) last saw the deceased alive on 9/24 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE A. E. SUBONG JR. | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-25-65 | |
| 23C. PHYSICIAN'S NAME (Type) A. E. SUBONG JR. | | 23D. ADDRESS Church Home & Hosp | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-27-65 | | 24C. NAME OF CEMETERY or CREMATORY Woodlawn | |
| 24D. LOCATION (City, town, or county) (State) Balto. Co. Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. | | | |
| | | ADDRESS 4905 York Rd. Balto., Md. | | | |

ARMY H. GORDON

CHIEF ENGINEER AND MECHANIC

435 KOSKOWSKY, AVE.

MADE CANZ DIRECTED AUG. 8, 1901 64

ENGINEER

MARYLAND

ARTHUR H. GORDON ROSE GUNTHIE

24-40-6666

Arthur H. Gordon
Capt. U.S. Army

Arthur H. Gordon
Capt. U.S. Army

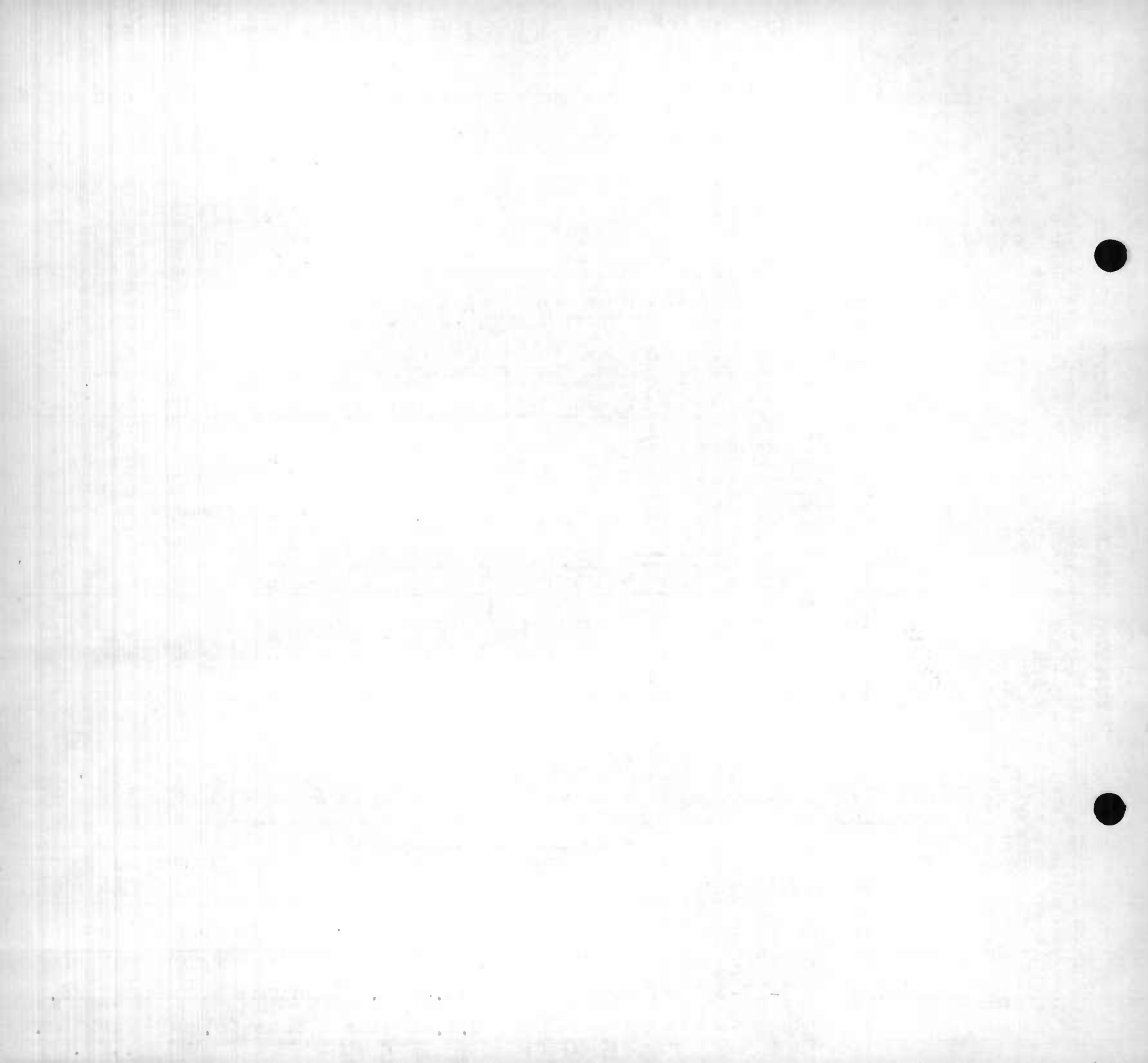
Arthur H. Gordon
Capt. U.S. Army

Arthur H. Gordon
Capt. U.S. Army

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

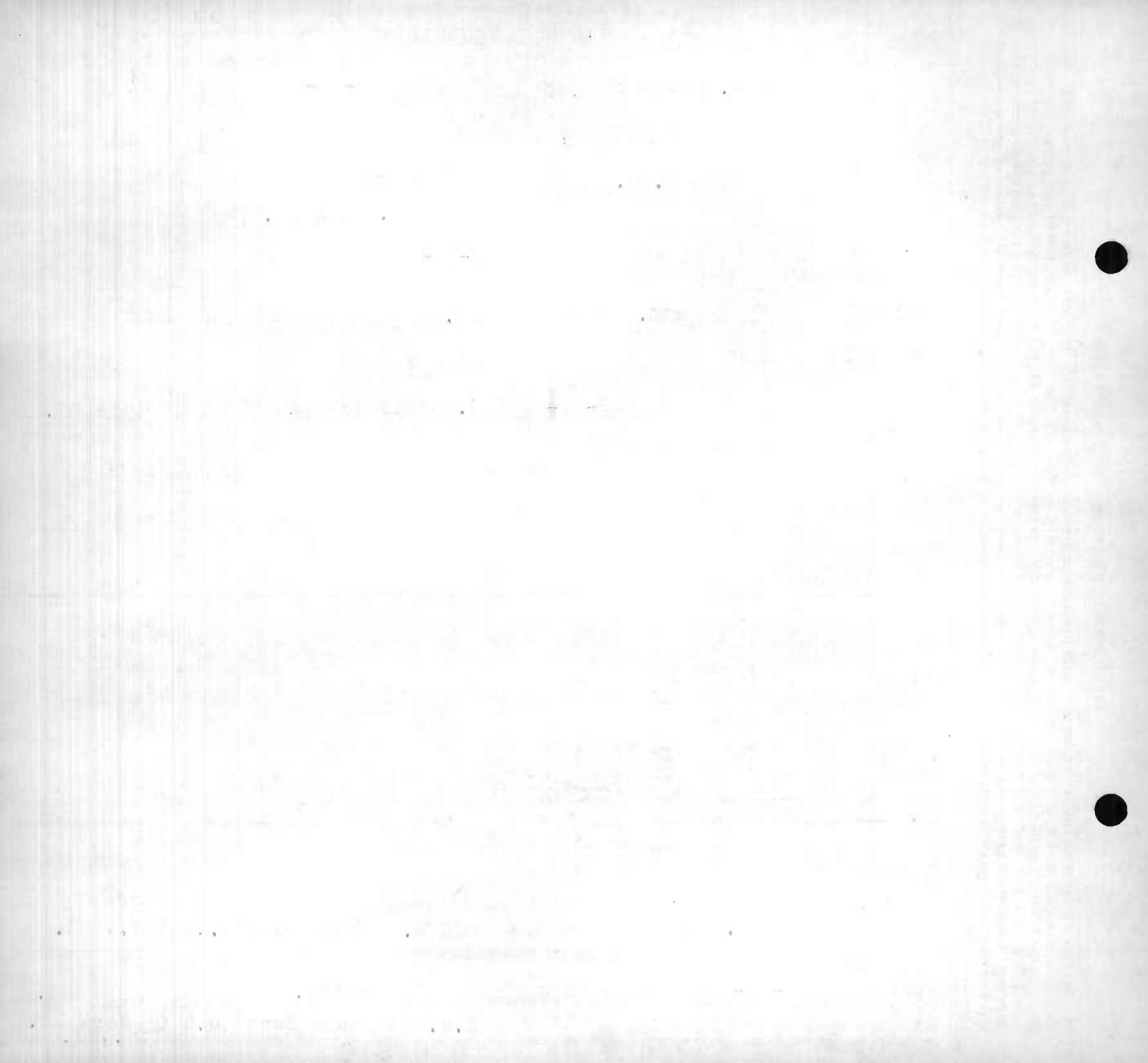
| BIRTH NO. 65 9892 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9892 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|----------------------------------------------------------------------|---------------------------------------------|
| M.E. CASE NO. | | | | BALTIMORE CITY HEALTH DEPARTMENT | | | |
| 1. NAME OF DECEASED (Type or Print) William McWherter | | | | 2. DATE AND HOUR OF DEATH September 25 1965 12¹¹ AM. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 2709 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4 SINAI HOSPITAL OF BALTIMORE, INC. BALTIMORE MD 21215 | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE CITY | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 1510 PENTRIDGE RD 21212 | | | |
| 5. SEX MALE | 6. RACE Cauc. | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 3/9/11 | 9. AGE (In years last birthday) 54 | 10. Under 1 Yr. Months | 10. Under 24 Hrs. Days | 10. Under 24 Hrs. Hours |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN | | | 10B. KIND OF BUSINESS OR INDUSTRY Meat packing | | 11. BIRTHPLACE (State or foreign country) KENTUCKY | | 12. CITIZEN OF WHAT COUNTRY? USA. |
| 13. FATHER'S NAME TOLBERT DALTON MCWHERTER | | | | 14. MOTHER'S MAIDEN NAME REBBECA TAYLOR | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 409-07-3595 | | 17. INFORMANT MRS. FRANCES B. MCWHERTER ABOVE | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Adenocarcinoma of Mediastinum - lung | | | | INTERVAL BETWEEN ONSET AND DEATH Condition diagnosed 1 month ago. | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cerebral metastasis - diagnosed 1 month ago. AND SQUAMOUS CELL CARCINOMA OF THE SUPRACLAVICULAR NODES | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from September 1 19 65 to Sept 25 19 65 , that (I) (we) last saw the deceased alive on Sept 25 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Allen H. Judman | | | | 23B. DATE SIGNED Sept 25, 1965 | | | |
| 23C. PHYSICIAN'S NAME (Type) ALLEN H. JUDMAN | | | | 23D. ADDRESS M.D. SINAI HOSPITAL OF BALTIMORE INC. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-27-65 | | 24C. NAME of CEMETERY or CREMATORY Dulaney Valley Mem. Gard. Timonium | | 24D. LOCATION (City, town, or county) (State) Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | 25B. NAME OF REGISTRAR Robert E. Fairbank | | 25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. | | ADDRESS 4905 York Rd. Balto., Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9893 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9893 | |
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| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Emma S. Leimbach | | | | 2. DATE AND HOUR OF DEATH 9-25-65 6:00 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Long Green N. H. | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 15-01 | | | |
| 5. SEX F 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed | | | | 8. DATE OF BIRTH 10-19-1886 | | 9. AGE (In years last birthday) 78 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical | | | | 10B. KIND OF BUSINESS OR INDUSTRY Dept. Store | | 11. BIRTHPLACE (State or foreign country) Md. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME Frederick Stumpf | | | |
| 14. MOTHER'S MAIDEN NAME Sophia Orth | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | |
| 16. SOCIAL SECURITY N. 212-09-9222 | | | | 17. INFORMANT H. Donald Schwaab ADDRESS 218 Tunbridge Rd. | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) GENERALIZED CARCINOMATOSIS | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH 3 MOS. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CARCINOMA, RT BREAST | | | | DUE TO | | 15 MOS. | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. GENERALIZED ARTERIOSCLEROSIS | | | | | | ? | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from MARCH 1963 to 9/25 1965 , that (I) (we) last saw the deceased alive on 9/24 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE John M. Scott | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9/25/65 | |
| 23C. PHYSICIAN'S NAME (Type) John M. Scott | | | | 23D. ADDRESS 600 W. Belvedere Ave., Balto., Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-27-65 | | 24C. NAME OF CEMETERY or CREMATORY Loudon Park | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | 25B. NAME OF REGISTRAR Robert E. Farkner | | 25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9894 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9894 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Dyson, William Bernard</i> | | 2. DATE AND HOUR OF DEATH <i>9-24-65 2:05 P.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | 5. STATE | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>The Union Memorial Hospital</i> | | A. STATE <i>Maryland</i> | | B. COUNTY <i>27-48</i> | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | | D. STREET ADDRESS (If rural, give location) <i>814 E. Lake Avenue</i> | |
| 5. SEX <i>Male</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i> | 8. DATE OF BIRTH <i>9/20/88</i> | 9. AGE (In years last birthday) <i>77</i> | 10. If Under 1 Yr. Months; Days; If Under 24 Hrs. Hours; Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRER</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>FLOUR MILL</i> | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>William H. Dyson</i> | | 14. MOTHER'S MAIDEN NAME <i>Margaret A. Burke</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>216-03-4676</i> | | 17. INFORMANT <i>Mrs. Goldie P. Dyson - Same as above</i> | |
| 18. <i>157X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <i>Carcinomatosis</i> DUE TO (B) <i>Carcinoma of head of pancreas</i> DUE TO (C) <i>SW</i> | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>39-6-65</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Exploratory Laparotomy</i> | | 20A. AUTOPSY? (Yes or No) <i>Yes</i> | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i> | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from <i>9/21 1965</i> to <i>9-24 1965</i> , that (I) (we) last saw the deceased alive on <i>9-24 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE <i>A. C. Linton, Jr.</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>9-24-65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>DR A. C. LINTON</i> | | 23D. ADDRESS <i>The Union Memorial Hospital</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>9/28/1965</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral</i> | |
| 24D. LOCATION <i>Baltimore, Md.</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 27 1965</i> | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Farber, M.D.</i> | | 25C. FUNERAL DIRECTOR <i>H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.</i> | | | |

T. 2.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|----------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|----------------------------------------------------------------------|-----------------------------------------------------------------------------------|--|
| BIRTH NO. 65 9895 | | | | | CERTIFICATE OF DEATH | | | | |
| M.E. CASE NO. | | | | | Registered No. 65 9895 | | | | |
| 1. NAME OF DECEASED (Type or Print) LEROY, GERDING | | | | | 2. DATE AND HOUR OF DEATH 9/25/65 3:00 P.M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY Balto | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GEN. HOSPITAL | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | | |
| D. STREET ADDRESS (If rural, give location) 605 HILLEN ROAD, FOWSON | | | | | | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) M | | 8. DATE OF BIRTH 5/11/1898 | 9. AGE (In years last birthday) 67 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAWYER | | | 10B. KIND OF BUSINESS OR INDUSTRY LAWYER | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, Md. | | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME JACOB GERDING | | | | | 14. MOTHER'S MAIDEN NAME ROSIE NORS | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT VERGINIA GERDING-JAMES | | | ADDRESS | |
| 18. 4 20.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction Coronary Artery Disease | | | | | CAUSE OF DEATH | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (A) DUE TO (B) DUE TO (C) DUE TO | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner) | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | |
| 21D. TIME OF INJURY (APPRDX.) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-23 19 65 to 9-25 19 65 , that (I) (we) last saw the deceased alive on 9-25 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Robert E. Jenkins M.D. | | | | | 23B. DATE SIGNED 9-25-65 | | | 23C. PHYSICIAN'S NAME (Type) ROBERT E. JENKINS M.D. | |
| 23D. ADDRESS MARYLAND GEN. HOSPITAL | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 24B. DATE 9/28/1965 | | 24C. NAME of CEMETERY or CREMATORY Dulaney Valley Cem. | | | 24D. LOCATION (City, town, or county) (State) Timonium, Balto. Co., Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | | 25B. NAME OF REGISTRAR Robert E. Jenkins | | 25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md. | | | | |

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CAMBRIDGE

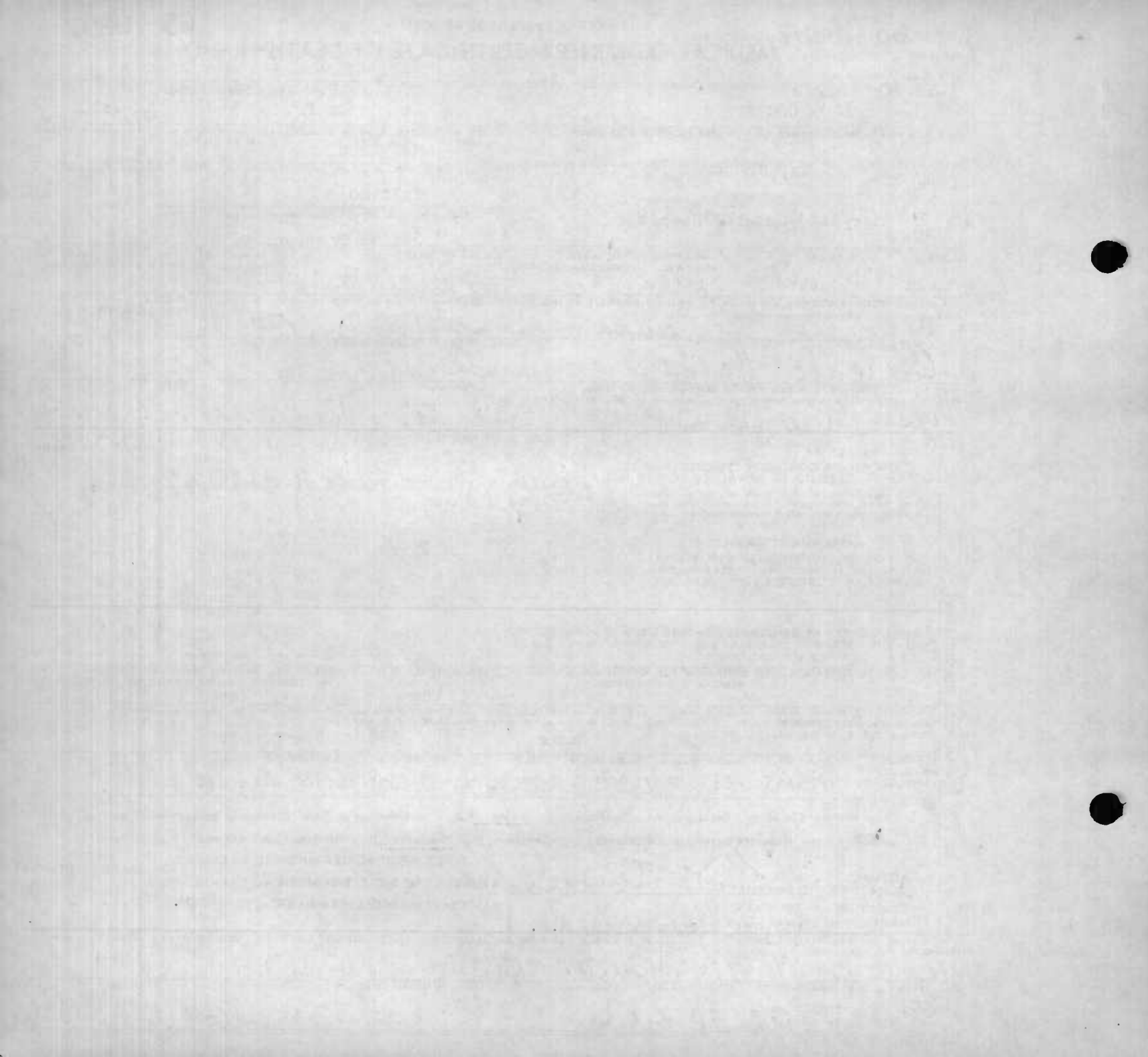
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9896 | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 65 9896 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Greenwood Hanna | | 2. DATE AND HOUR OF DEATH 9-25-65 11:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital | | A. STATE Maryland | | B. COUNTY 9-06 | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN Baltimore | | (If outside city limits, write RURAL and give township) | |
| | | D. STREET ADDRESS 3221 Alameda | | (If rural, give location) | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) NEVER MARRIED | 8. DATE OF BIRTH 4-3-82 | 9. AGE (In years last birthday) 83 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY VOCALIST | | 11. BIRTHPLACE (State or foreign country) BALTO. Md. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME BENJAMIN GREENWOOD | | 14. MOTHER'S MAIDEN NAME AGUSTA HERRING | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT GEORGE N. STUMPTNER | |
| | | | | ADDRESS 3900 N. CHARLES ST. | |
| 18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral Vascular Accident | | CAUSE OF DEATH (A) Cerebral Vascular Accident DUE TO (B) Arteriosclerosis DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept. 25 19 65 to Sept. 25 19 65 , that (I) (we) last saw the deceased alive on Sept 25 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Rodney L. Brimhall | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-25-65 | |
| 23C. PHYSICIAN'S NAME (Type) RODNEY L. BRIMHALL, | | M.D. | | 23D. ADDRESS UNION MEMORIAL HOSPITAL | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/29/1965 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore | |
| 24D. LOCATION Baltimore | | (City, town, or county) | | (State) Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 27 1965 | | 25B. NAME OF REGISTRAR Robert E. Talbot | | 25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. | |
| | | | | ADDRESS 4905 York Rd. Balto. 12, Md. | |

THE UNIVERSITY OF CHICAGO

| 65 9897 | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 9897 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) LEON COCKEY | | | 2. DATE AND HOUR PRONOUNCED DEAD Sept. 25, 1965 7:10 P.M. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hospital | | | A. STATE Maryland B. COUNTY | | |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 17-02 | | |
| | | | D. STREET ADDRESS (If rural, give location) 598 W. Preston St. | | |
| 5. SEX male | 6. RACE negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH May 12, 1925 | 9. AGE (In years last birthday) 40 | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY union | 11. BIRTHPLACE (State or foreign country) Baltimore Md | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME Clarence Cockey | | | 14. MOTHER'S MAIDEN NAME Isabell | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes WWII | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS Constance Cockey - 2412 Chelsea Ave. | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple gunshot wounds of the chest and abdomen ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 598 W. Preston St. | |
| 21D. TIME OF INJURY (APPROX.) 9/25/65 5:30 P.M. | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Shot during altercation | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breitenecker, M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 23B. DATE 9/29/65 | | 23C. NAME OF CEMETERY or CREMATORY Balt. Nat. Cem. |
| 23D. LOCATION (City, town, or county) (State) Balt. Md | | | 24A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | |
| 24B. NAME OF REGISTRAR Robert E. F... | | | 24C. FUNERAL DIRECTOR ADDRESS Carl Gilmore - 1827 W. North Ave | | |



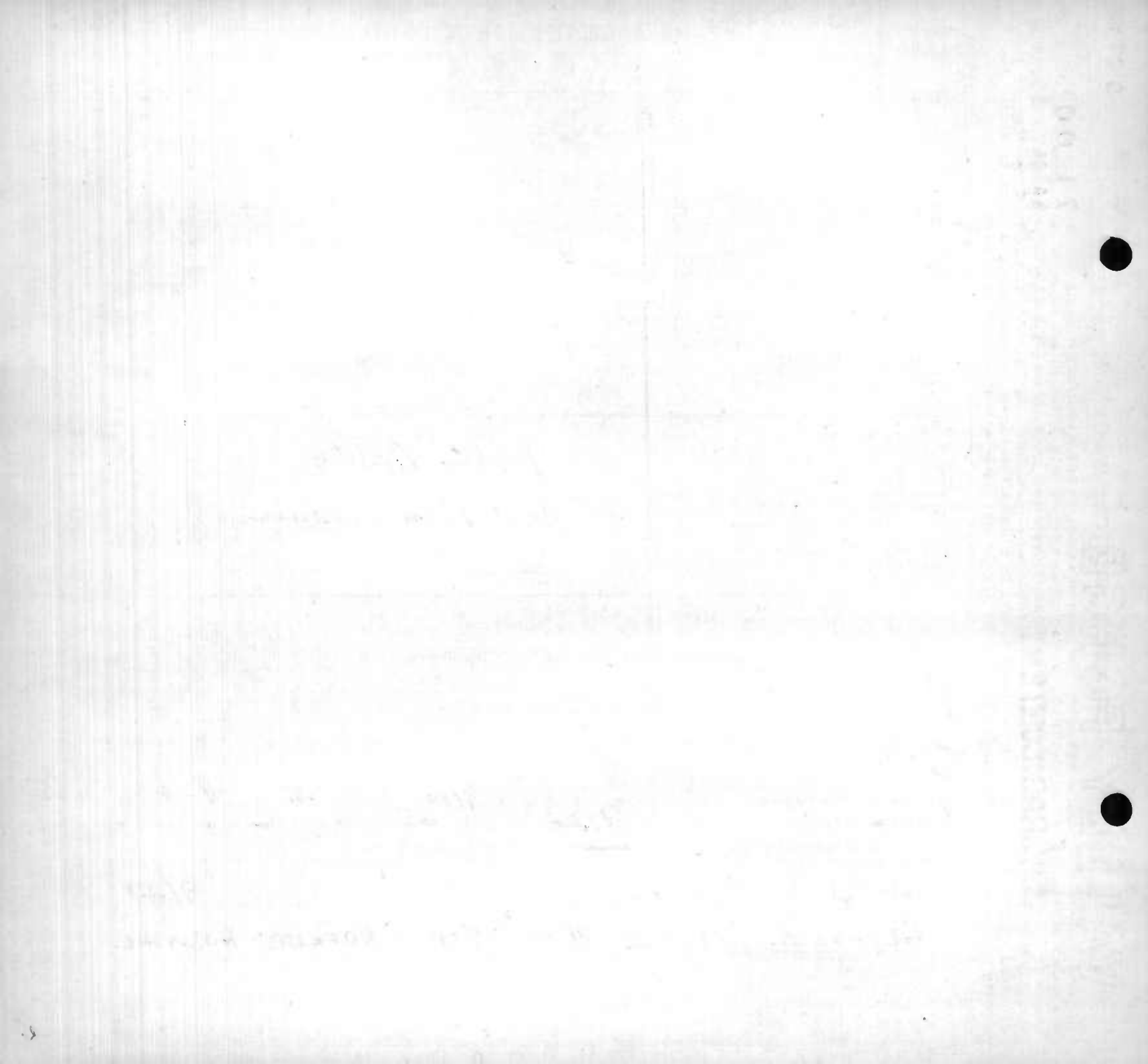
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death is shown: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined; (5) D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9898 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9898 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Solomon Major | | 2. DATE AND HOUR OF DEATH 9-27-65 2:50 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) 5-81 | |
| FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital | | D. STREET ADDRESS (If rural, give location) 1207 McCubbin Court | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 3-18-93 | 9. AGE (In years lost birthday) 72 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) South Boston, VA. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Louis Solomon | | 14. MOTHER'S MAIDEN NAME Octave Reed | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Florence Major | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 260X I | | CAUSE OF DEATH (A) Diabetic Mellitus DUE TO (B) Renal Debris & Uremia DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH SAME | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/10 19 65 to 9/27 19 65, that (I) lost saw the deceased alive on 9/26 19 65 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE George A. Schuele III | | M.D. Attending Phys. <input checked="" type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9/27 | |
| 23C. PHYSICIAN'S NAME (Type) GEORGE A. SCHEULE III | | 23D. ADDRESS JOHNS HOPKINS HOSPITAL | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 10-1-65 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem. | |
| 24D. LOCATION Brooklyn, Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley | |
| 25C. FUNERAL DIRECTOR E. O. Wilson | | ADDRESS 1000 Brawthey Ave. | | | |



FUNERAL DIRECTOR: IMPORTANT

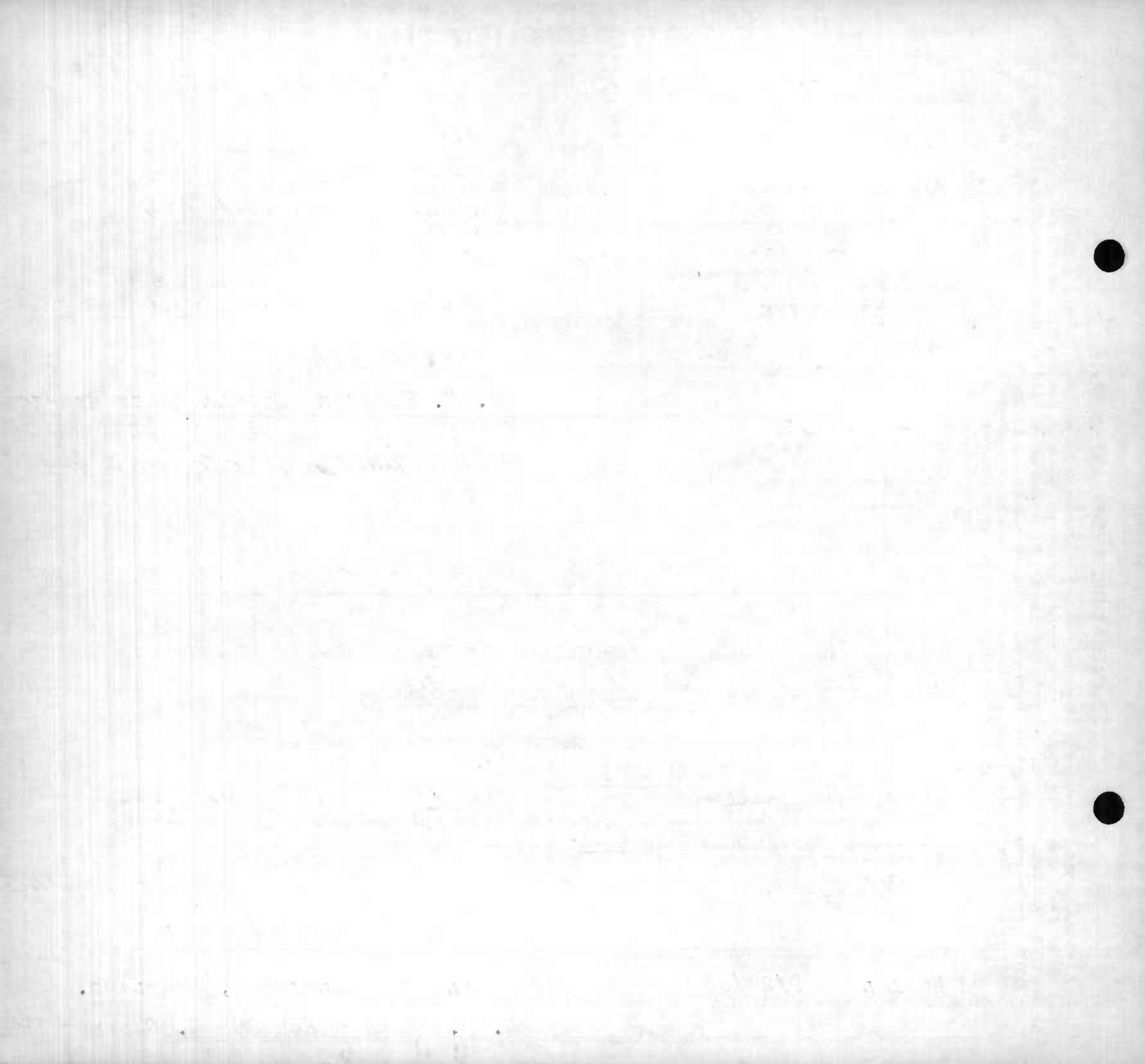
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9899 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9899 | |
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| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) LUI, MRS. CARMELLA. | | | | 2. DATE AND HOUR OF DEATH 9-25-1965 3⁴⁵ P. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND: FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 34 BON SECOURS HOSPITAL, BALTO. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1-05 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2212 E. PRATT ST. | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 1-16-1918 | 9. AGE (In years last birthday) 47 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H. W. | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, M.D. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME DOMINIC POTENZIAND | | | | 14. MOTHER'S MAIDEN NAME MINNIE | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT MR. ERNEST POTENZIAND ADDRESS 2212 E. PRATT ST. BALTIMORE 31 | |
| 18. 476X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CEREBRAL VASCULAR ACCIDENT ONE DAY ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. RHEUMATIC HEART DISEASE YEARS | | | | (A) DUE TO (B) DUE TO (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CONTRACTURE OF URINARY BLADDER SEVERAL MONTHS | | | | | | | |
| 19A. DATE OF OPERATION 09-22-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CONTRACTURE OF U. BLADDER | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/> While At Work <input type="checkbox"/> At Home <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-20 1965 to 9-25 1965 , that (I) (we) last saw the deceased alive on 9-25 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE ZIN U. PARK | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-25-65 | |
| 23C. PHYSICIAN'S NAME (Type) ZIN U. PARK | | | | 23D. ADDRESS % Mon Secours Hospital, BALTO. MD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-29-65 | | 24C. NAME of CEMETERY or CREMATORY St. Andrew's of Mary Baltimore | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR Frank W. Ozagowski | | ADDRESS 1930 Eastern Ave | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9900 | |
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| BIRTH NO. 65 9900 | | | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) <i>Foley Anita B.</i> | | | | Sept. 25, 1965 8 ⁵⁵ A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Mercy Hospital</i> | | | | A. STATE <i>Md.</i> B. COUNTY <i>25-41</i> | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | |
| | | | | D. STREET ADDRESS (If rural, give location) <i>Jenkins Memorial Hosp.</i> | |
| 5. SEX <i>#</i> | 6. RACE <i>Caucasian</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i> | 8. DATE OF BIRTH <i>10-5-84</i> | 9. AGE (In years lost birthday) <i>80</i> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <i>Baltimore Co.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> |
| 13. FATHER'S NAME <i>William J. Bach</i> | | | 14. MOTHER'S MAIDEN NAME <i>Rose Kuhn</i> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS <i>Sr. M. ROSAIRE STELLA MARIS HOSPICE</i> | | |
| 18. <i>3-70.51</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) <i>Partial Intentional Obstr.</i> DUE TO (B) DUE TO (C) DUE TO | |
| INTERVAL BETWEEN ONSET AND DEATH <i>~ 12 days</i> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>No</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Sept 17</i> 19 <i>65</i> to <i>Sept. 25</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>Sept. 25</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Mary Jim Ratner</i> M.D. | | | | 23B. DATE SIGNED <i>Sept. 25 1965</i> | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS <i>Mercy Hospital Box 98</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 24B. DATE <i>9/28/65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>NEW CATHEDRAL</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, MARYLAND.</i> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 28 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Finkbeiner</i> | | 25C. FUNERAL DIRECTOR ADDRESS <i>H. W. MEARS & SON 805 N. CALVERT STR.</i> | |

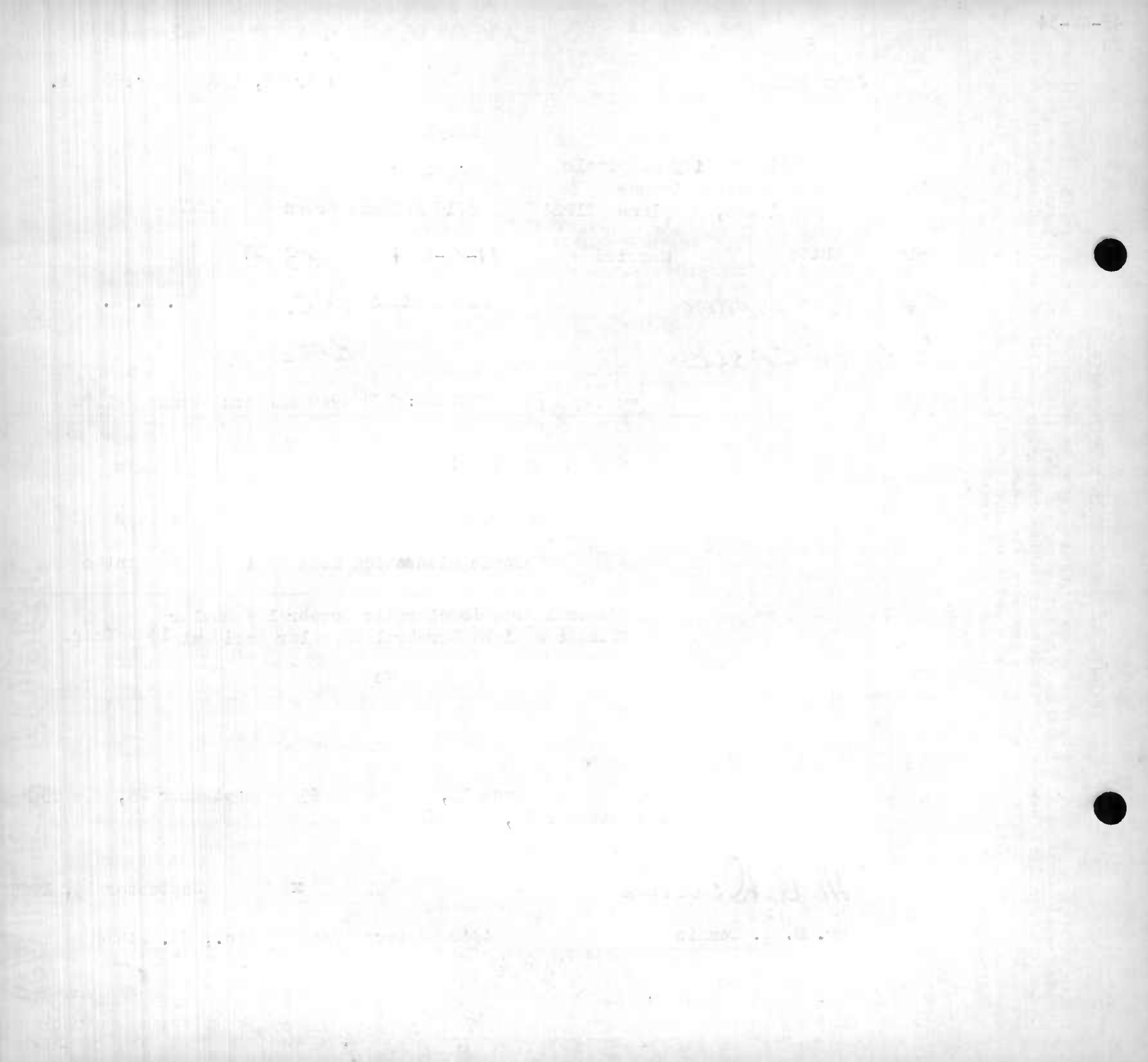


43-47-34
FR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9901 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9901 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED (Type or Print) John Caslow | | | | 2. DATE AND HOUR OF DEATH September 25, 1965 4:50 A. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balto C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 4715 Belwood Green 21227 | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 14-27-1888 | 9. AGE (In years last birthday) 83 yr | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CABINET MAKER | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Mississippi MO. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME W.M. H. CASLOW | | | | 14. MOTHER'S MAIDEN NAME BATEMAN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 577-09-4569 | | 17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue 21224 | | | |
| 18. 715X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Septicemia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Gangrene Left Foot Chronic Ulceration Left Foot | | | | INTERVAL BETWEEN ONSET AND DEATH 4 Days 7 Days 2 1/2 Months | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. General Arteriosclerotic Cerebral Vascular Disease & Right Cerebral Vascular Accident 13 + Years | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 15, 1965 to September 25, 1965 , that (I) (we) last saw the deceased alive on September 25, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE M. A. Dennis | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED September 25, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Dr. M. A. Dennis | | | | 23D. ADDRESS 4940 Eastern Avenue Balto., Md. 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-27-65 | | 24C. NAME OF CEMETERY OR CREMATORY St Pauls Church Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR Edw. R. MacArthur | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Certificate of Death | | Registered No. 65 9902 | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------|--|
| BIRTH NO. 65 9902 | | | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) CHRISTMAS, WILLIAMS ^{REESE} REES | | | | 2. DATE AND HOUR OF DEATH 9/25/65 4:27 PM | | M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND (First) SINAI HOSP. of BALTO., INC. (Middle) WILLIAMS (Last Name) REES | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSP. of BALTO., INC. | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) CATONSVILLE | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 303 BEAUMONT AVE 21228 | | | |
| 5. SEX MALE | | 6. RACE CAUCASIAN | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | | 8. DATE OF BIRTH 12/25/02 | |
| | | | | 9. AGE (in years last birthday) 62 | | If Under 1 Yr. Months: Days: Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER | | | | 10B. KIND OF BUSINESS OR INDUSTRY FOOD DISTRIBUTION | | 11. BIRTHPLACE (State or foreign country) SCRANTON, PA. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME EDWIN WALTER WILLIAMS | | | | 14. MOTHER'S MAIDEN NAME RACHEAL GRIFFITH | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT JAMES REESE WILLIAMS | |
| | | | | ADDRESS 204 MURGATE LANE OWINGS MILLS MD. | | | |
| 18. 200.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) RT. RENAL INVOLVEMENT DUE TO OBSTRUCTION OF R URETER | | | | CAUSE OF DEATH (A) RT. RENAL INVOLVEMENT DUE TO OBSTRUCTION OF R URETER (B) RETROPERITONEAL SARCOMA (C) RETICULUM CELL SARCOMA | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | INTERVAL BETWEEN ONSET AND DEATH > 2 MOS. > 2 MOS. > 2 MOS. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. PEPTIC ULCERATION | | | | 4 YRS. | | | |
| 19A. DATE OF OPERATION JULY 27, 1965 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED HYDRONEPHROSIS | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NONE | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NONE | | | |
| 21D. TIME OF INJURY (APPROX.) NONE | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> NONE | | 21F. HOW DID INJURY OCCUR? NONE | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/3/65 to 9/25 19 65 , that (I) (we) last saw the deceased alive on 9/25 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Joseph S. Weinstock | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/25/65 | |
| 23C. PHYSICIAN'S NAME (Type) Joseph S. Weinstock | | | | 23D. ADDRESS Sinai Hosp. of Balto. Inc. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Sept 28, 1965 | | 24C. NAME of CEMETERY or CREMATORY Lakeview Cemetery | | 24D. LOCATION (City, town, or county) (State) Carroll County, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Sterling Funeral Estate | | ADDRESS Catonville, Md. 736 Edmonds Ave. | |

1. The first of these is the fact that the
the American people are not yet
the American people are not yet
the American people are not yet

2. The second of these is the fact that the
the American people are not yet
the American people are not yet
the American people are not yet

3. The third of these is the fact that the
the American people are not yet
the American people are not yet
the American people are not yet

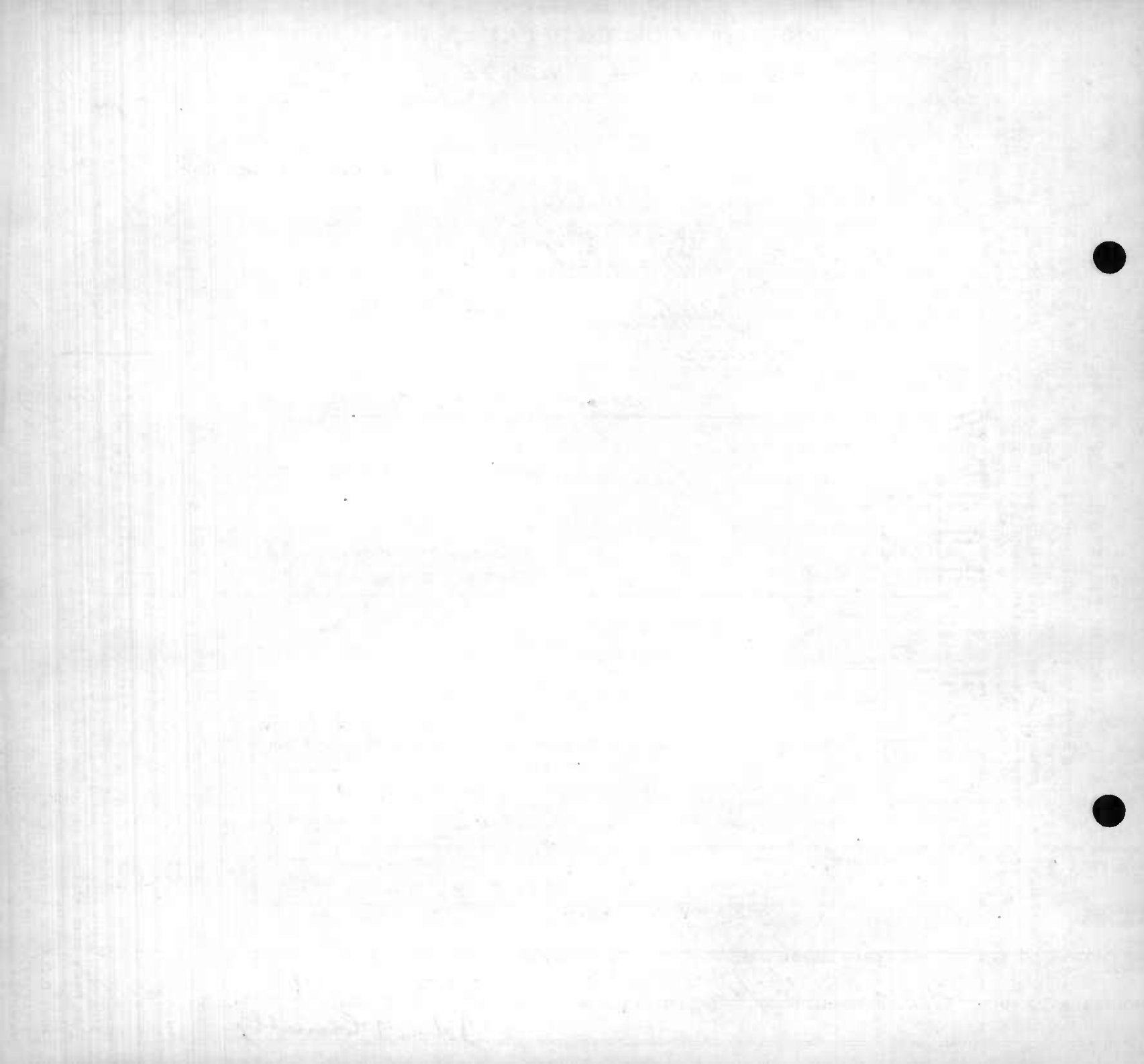
4. The fourth of these is the fact that the
the American people are not yet
the American people are not yet
the American people are not yet

5. The fifth of these is the fact that the
the American people are not yet
the American people are not yet
the American people are not yet

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 65 9903 | | CERTIFICATE OF DEATH | | Registered No. 65 9903 | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|-------------------------------------------------|--|
| 1. NAME OF DECEASED (Type or Print) HELEN M. HEISEY. | | | | 2. DATE AND HOUR OF DEATH 9/24/65 5:10 PM. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Gould Conv. Home | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto. C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Co. (24) D. STREET ADDRESS (If rural, give location) 7820 Shynbrook Rd. | | | | | |
| 5. SEX Female | | 6. RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | | 8. DATE OF BIRTH 2/17/15 | | 9. AGE (In years last birthday) 50 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sec. Board of C.D. (Balto. Co.) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Penn. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Miller | | | | 14. MOTHER'S MAIDEN NAME ? | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 180-05-5875 | | 17. INFORMANT Husband (Same as above) | | | |
| 18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of Lung ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. with metastasis to cervical nodes and partly Liver | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH ? | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 9/21/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) — | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 7:30 | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/21/65 to 9/24/65 , that (I) (we) last saw the deceased alive on 9/24/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE V. Sadarananda M.D. | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9/24/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) V. SADARANANDA A. | | | | 23D. ADDRESS M.D. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/27/65 | | 24C. NAME OF CEMETERY or CREMATORY Gardens of Faith | | 24D. LOCATION (City, town, or county) Balto. | | (State) Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR John J. Connelly | | ADDRESS 300 more Ave 21 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9904 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 9904 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------|------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|-------------------------------------------------------------------------|-----------------------|--------------------------------------------------------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) MARITHA BAKER | | 2. DATE AND HOUR OF DEATH 9/24/65 11:35 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | 5. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 36 Franklin Square Hospital | | | | A. STATE MD | | B. COUNTY Baltimore | | | |
| (If not in hospital or institution, give street address or location) | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. 21, Md | | D. STREET ADDRESS (If rural, give location) 5300 | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed | 8. DATE OF BIRTH 7/30/93 | 9. AGE (In years lost birthday) 72 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | | | |
| 13. FATHER'S NAME unknown Harrison | | | | 14. MOTHER'S MAIDEN NAME unknown | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown | | | | 16. SOCIAL SECURITY NO. 215-05-4352A | | 17. INFORMANT John T. Stubb | | ADDRESS 956 N. Maryland Ave | |
| 18. 20.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Antecedent causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH (A) Ventricular fibrillation DUE TO (B) Arteriosclerotic heart disease DUE TO (C) | | | | INTERVAL BETWEEN ONSET AND DEATH 10-20 minutes years | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/14 19 65 to 9/24 19 65 , that (I) (we) last saw the deceased alive on 9/24 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE RAYMUNDO S. MAGNOD | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/24/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) RAYMUNDO S. MAGNOD | | | | 23D. ADDRESS Franklin Square Hospital | | | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/28/65 | | 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemed | | 24D. LOCATION (City, town, or county) (State) Balto. Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | 25B. NAME OF REGISTRAR John E. Farley | | 25C. FUNERAL DIRECTOR ADDRESS John J. Connelly, 300 Main Ave., 21 | | | | | |

The body of Marguerite Brown was released to the Johns Hopkins Hospital by

Dr. Brictnacker on approval 9-22-65 **FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------|------------------------------------------|
| B-65065 9905 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9905 | |
| BIRTH NO. | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Marguerite Johnson (Brown, Frey) | | 9-22-65 | | 13:25 a M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | A. STATE B. COUNTY | | | |
| Johns Hopkins Hospital | | Baltimore, Md. 5-01 | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 1237 E. Monument St. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | If Under 1 Yr. Months Days Hours Min. |
| Female | Negro | Separated | 3-3-22 | 43 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| None | | | | North Carolina | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Unknown | | Unknown | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | Hospital record. HELEN WILLIAMS 1840 N. CHESTER | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| Tracheo-pulmonary hemorrhage 15 min. | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | Klebsiella pneumonia to and septiscemia Chronic alcoholism | | At least 2 days Years | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 9-21-65 | | Tracheal secretions | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At <input type="checkbox"/> Not While Work At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) was hospital attended the deceased from 9-21-65 19 to 9-22-65 19 that (I) last saw the deceased alive on 9-22-65 19 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) we (did) view view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Edgar W. Hull | | | | 9-22-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| Edgar W. Hull | | | | Johns Hopkins Hospital | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 9-28-65 | | MT CALVARY | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 24D. LOCATION (City, town, or county) (State) | |
| SEP 28 1965 | | Robert E. Farber | | A.A. COUNTY Md | |
| 25C. FUNERAL DIRECTOR | | ADDRESS | | | |
| JOSEPH H. KNIGHT | | 1639 N. BROADWAY | | | |



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

EVA JACKSON

2. DATE AND HOUR PRONOUNCED DEAD

September 25, 1965 8:55 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore 21222

D. STREET ADDRESS (If rural, give location)

1807 Merritt Blvd.

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

widowed

8. DATE OF BIRTH

Aug. 13, 1888

9. AGE (In years
last birthday)

77 76

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William G. Moore

14. MOTHER'S MAIDEN NAME

Elizabeth Newton

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

239-10-3008

17. INFORMANT

Mrs. William H. Walp

ADDRESS

same as #1

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Sept. 26, 1965

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/29/65

23C. NAME of CEMETERY or CREMATORY

Lafayette Memorial Park Fayetteville, North Carolina

23D. LOCATION

(City, town, or county) (State)

24A. DATE REC'D BY HEALTH DEPT.

SEP 28 1965

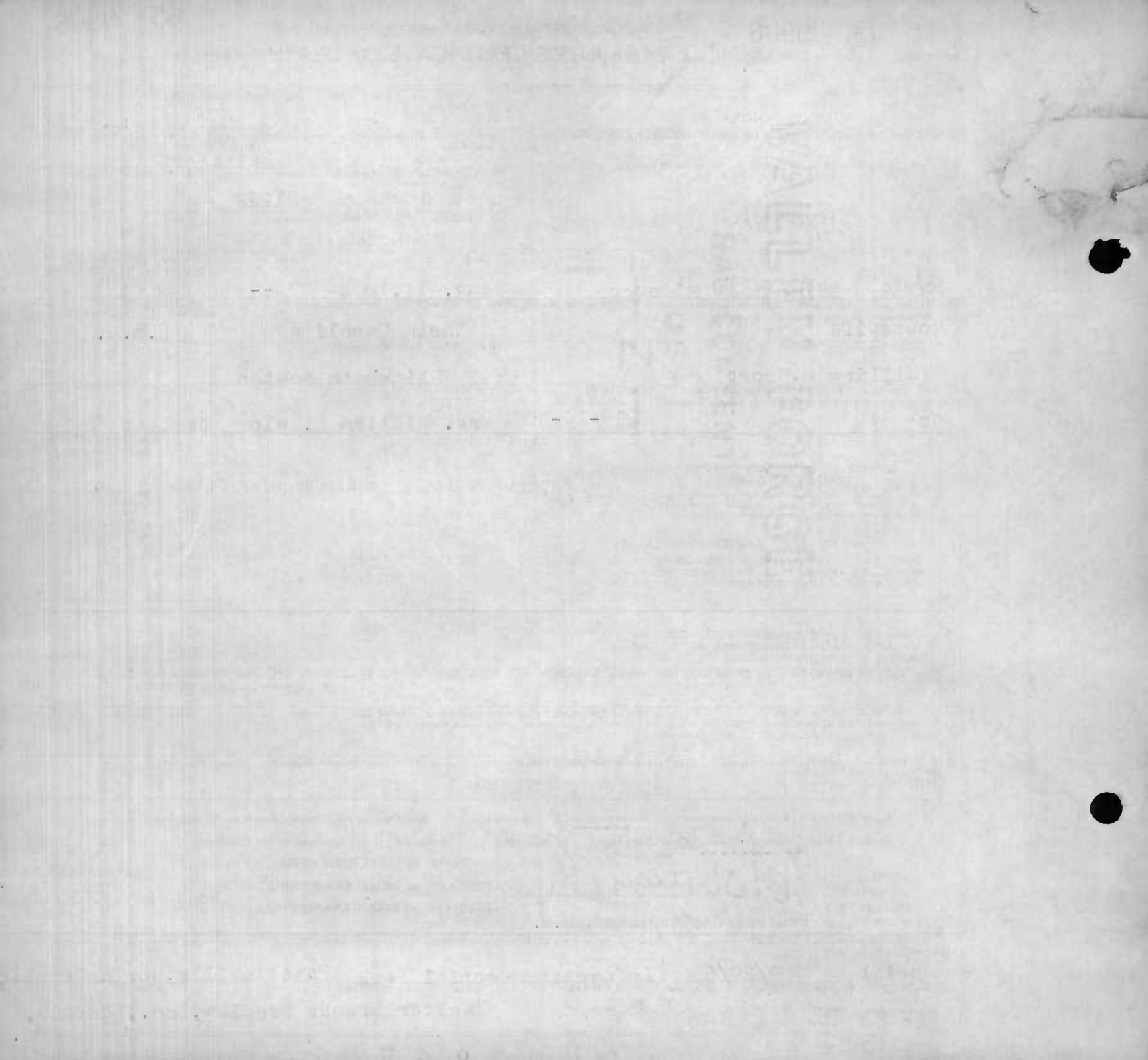
24B. NAME OF REGISTRAR

Robert E. Farker, M.D.

24C. FUNERAL DIRECTOR

Walter Brooks Bradley, Inc., Dundalk,
Md.

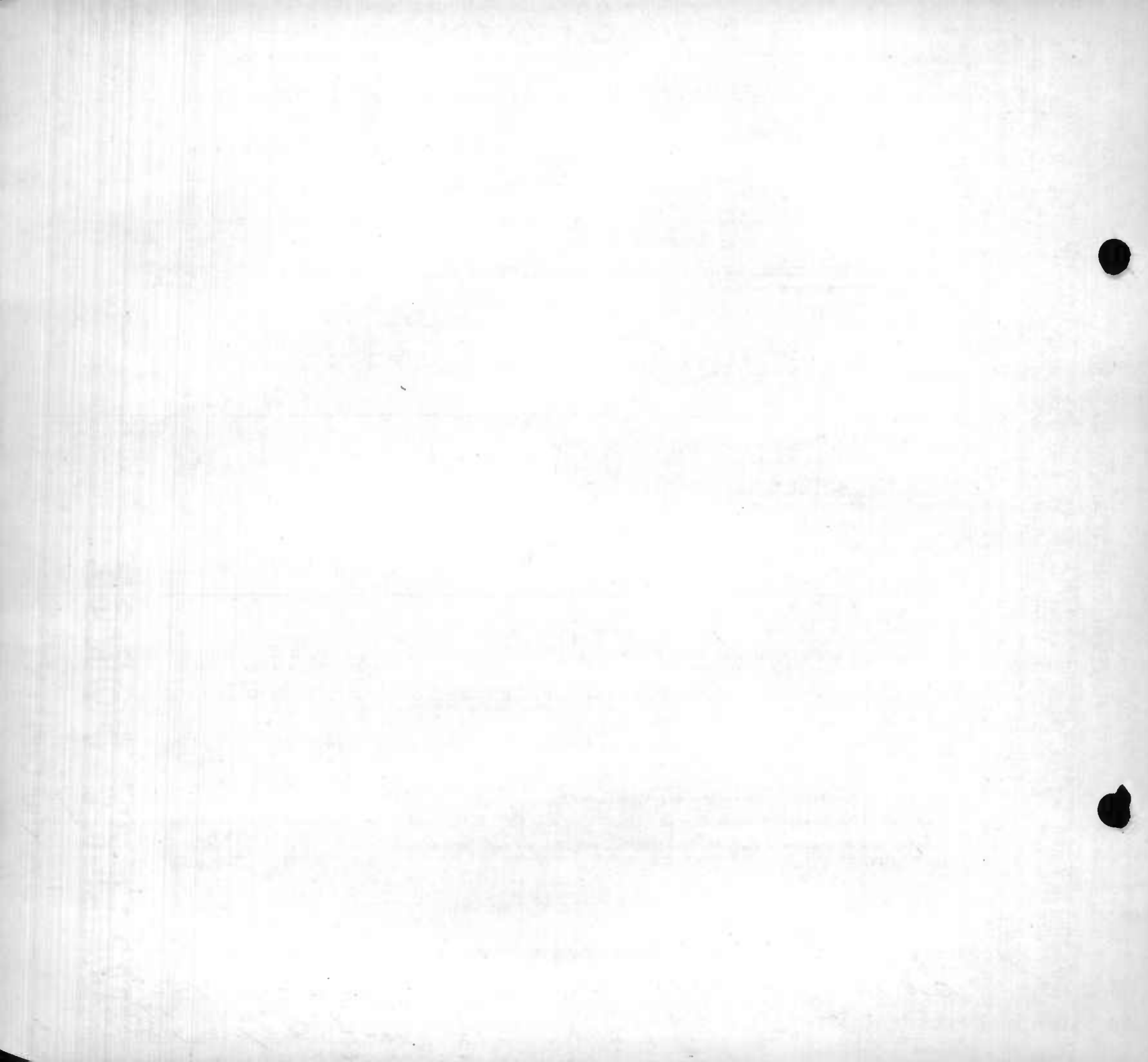
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

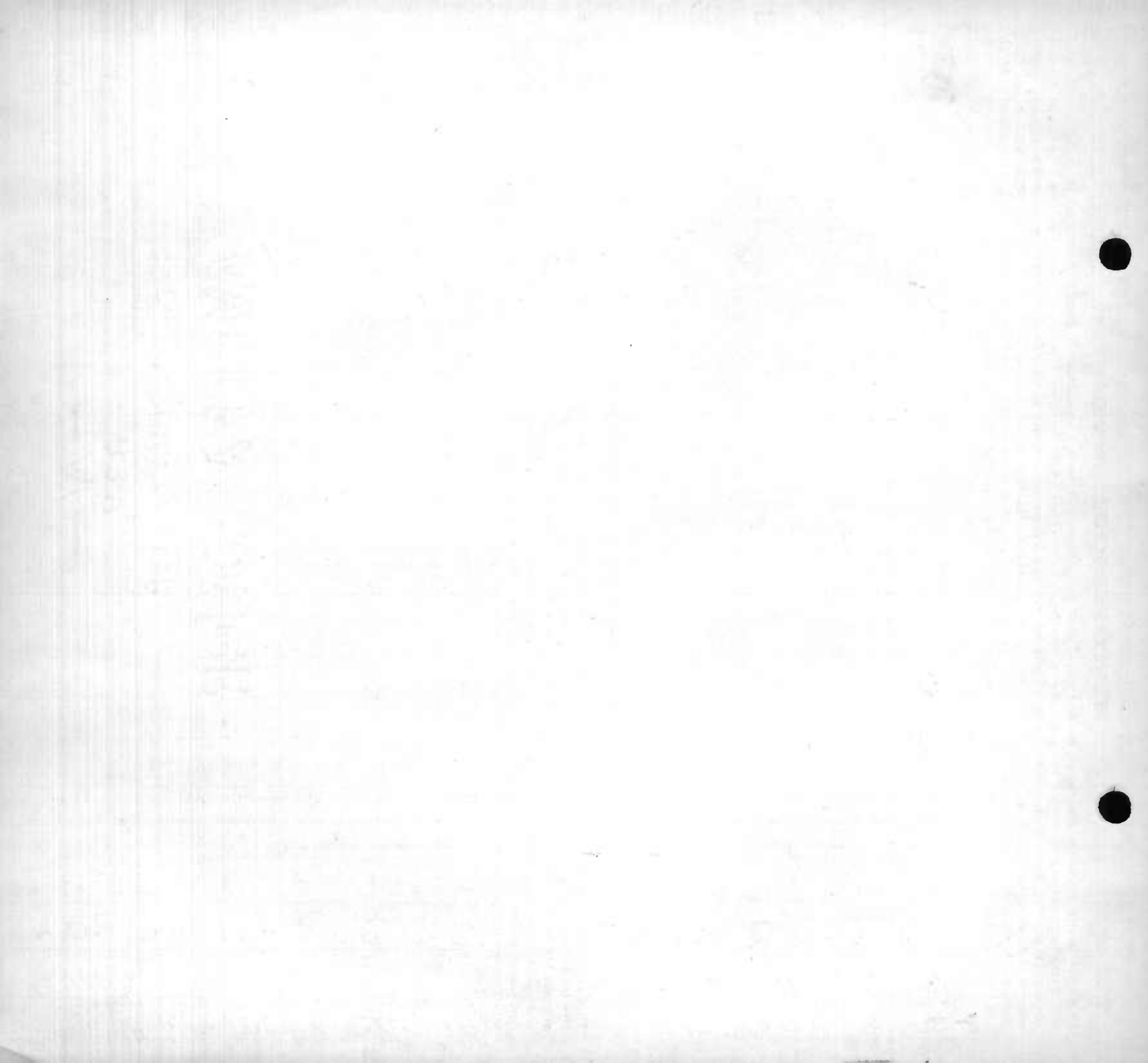
| | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|---------------------------------------------------------------------------------------------|------------------------------------------|
| BIRTH NO. 65 9907 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9907 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) WILKINS, Mr. Chetuis | | 2. DATE AND HOUR OF DEATH 9-22-65 3¹⁵ AM M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 13-02 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4 Maryland Gen. Hospital | | D. STREET ADDRESS (If rural, give location) 2107 Mt. Royal | | TOWN Terre | |
| 5. SEX M | 6. RACE C | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 11/7/15 | 9. AGE (In years last birthday) 52 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) N.C. | |
| 13. FATHER'S NAME General Wilkins | | 14. MOTHER'S MAIDEN NAME Levy | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 210-62-6939 | | 17. INFORMANT Ray Wilkins - son ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 381X I | | CAUSE OF DEATH intra cerebral hemorrhage | | INTERVAL BETWEEN ONSET AND DEATH 3 hrs. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Yes | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept. 20 1965 to Sept 21 1965 , that (I) (we) last saw the deceased alive on Sept 21 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Robert E. Farber | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-22-65 | |
| 23C. PHYSICIAN'S NAME (Type) Robert E. Farber | | M.D. Maryland Gen. Hospital | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/25/65 | | 24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Dist. Co. Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | 25B. NAME OF REGISTRAR Robert E. Farber | |
| 25C. FUNERAL DIRECTOR Archibald S. Phillips | | ADDRESS 214 N. Greenlee St. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9908 | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|-----------------------------------------------------------------------------|--------------------------------------------------|
| BIRTH NO. 65 9908 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED AARON TOWNSEND | | 2. DATE AND HOUR OF DEATH 9-25-65 8:30 A.M. | |
| 1. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1901 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 529 N. FULTON AVE. Baltimore Md. | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore City | | | |
| | | D. STREET ADDRESS (If rural, give location) 529 N. FULTON Ave | | | |
| 5. SEX M | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SEPARATED | 8. DATE OF BIRTH 10-7-14 | 9. AGE (In years last birthday) 51 | If Under 1 Yr. Months Days If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Clerk | | 10B. KIND OF BUSINESS OR INDUSTRY Clothing Mfg. | | 11. BIRTHPLACE (State or foreign country) Virginia | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Thomas Townsend | | | 14. MOTHER'S MAIDEN NAME LETTIE — ? | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 200-10-5898 | | 17. INFORMANT Minnie Townsend 1120 E. Pratt St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ADENOCARCINOMA. disseminated | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) DUE TO Presumed to be Prostatic Gland in origin. | | (B) DUE TO ANEMIA secondary to Bone marrow INVASION | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 9-23-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from JULY 1 1965 to 9-25 1965 , that (I) (we) last saw the deceased alive on 9-23 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE William R Birt | | | | 23B. DATE SIGNED 9-25-65 | |
| 23C. PHYSICIAN'S NAME (Type) WILLIAM R BIRT | | | | 23D. ADDRESS 1230 Druid Hill Ave Baltimore Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/29/65 | | 24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Ch. Baltimore Md. | |
| 24D. LOCATION (City, town, or county) (State) Md. | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR William S. Phillips 1727 N. Monmouth St. | |



1
B-650

65 9909

BALTIMORE CITY HEALTH DEPARTMENT

65 9909

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)Bernette
BERSETTA

BROWN

2. DATE AND HOUR PRONOUNCED DEAD

September 22, 1965

7:55 P.^{M.}

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1611 N. Payson Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Separated

8. DATE OF BIRTH

2/6/1938

9. AGE (In years
last birthday)

27

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

House wife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Enos Johnson

14. MOTHER'S MAIDEN NAME

Mary Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mary Johnson 1611 N. Payson St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) Rheumatic Heart Disease with Ball

Valve Thrombus of Left Atrium.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Petty M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/23/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9/27/65

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary

23D. LOCATION (City, town, or county)

Anne Arundel Co. Md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 28 1965

24B. NAME OF REGISTRAR

Robert E. Farley M.D.

24C. FUNERAL DIRECTOR

William S. Phillips 1727 N. Main St.

W/ALFRED PROIRGE

NO. 100-100000

100-100000

WALTER P. G.

65 9911

BALTIMORE CITY HEALTH DEPARTMENT

65 9911 ✓

BIRTH NO. 45-21082 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

M.E. CASE NO. _____

1. NAME OF DECEASED
(Type or Print) **ANTONIO TONY SYKES** 2. DATE AND HOUR PRONOUNCED DEAD
9-27-65 7:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland** B. COUNTY _____

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

1422 Madison Avenue

1422 Madison Avenue

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

8/21/65

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

6 weeks

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Amos Sykes

14. MOTHER'S MAIDEN NAME

Barbara Berry

15. WAS DECEASED EVER IN U.S. ARMED FORCES
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Barbara Sykes 1422 Madison Ave.

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) _____
DUE TO Interstitial pneumonitisINTERVAL BETWEEN
ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

CHIEF MEDICAL EXAMINER ☒

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9-27-65

23A. BURIAL CREMATION,
REMOVED (Specify)

Burial

23B. DATE

9/29/65

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary

23D. LOCATION

(City, town, or county)

(State)

Anne Arundel Co., Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

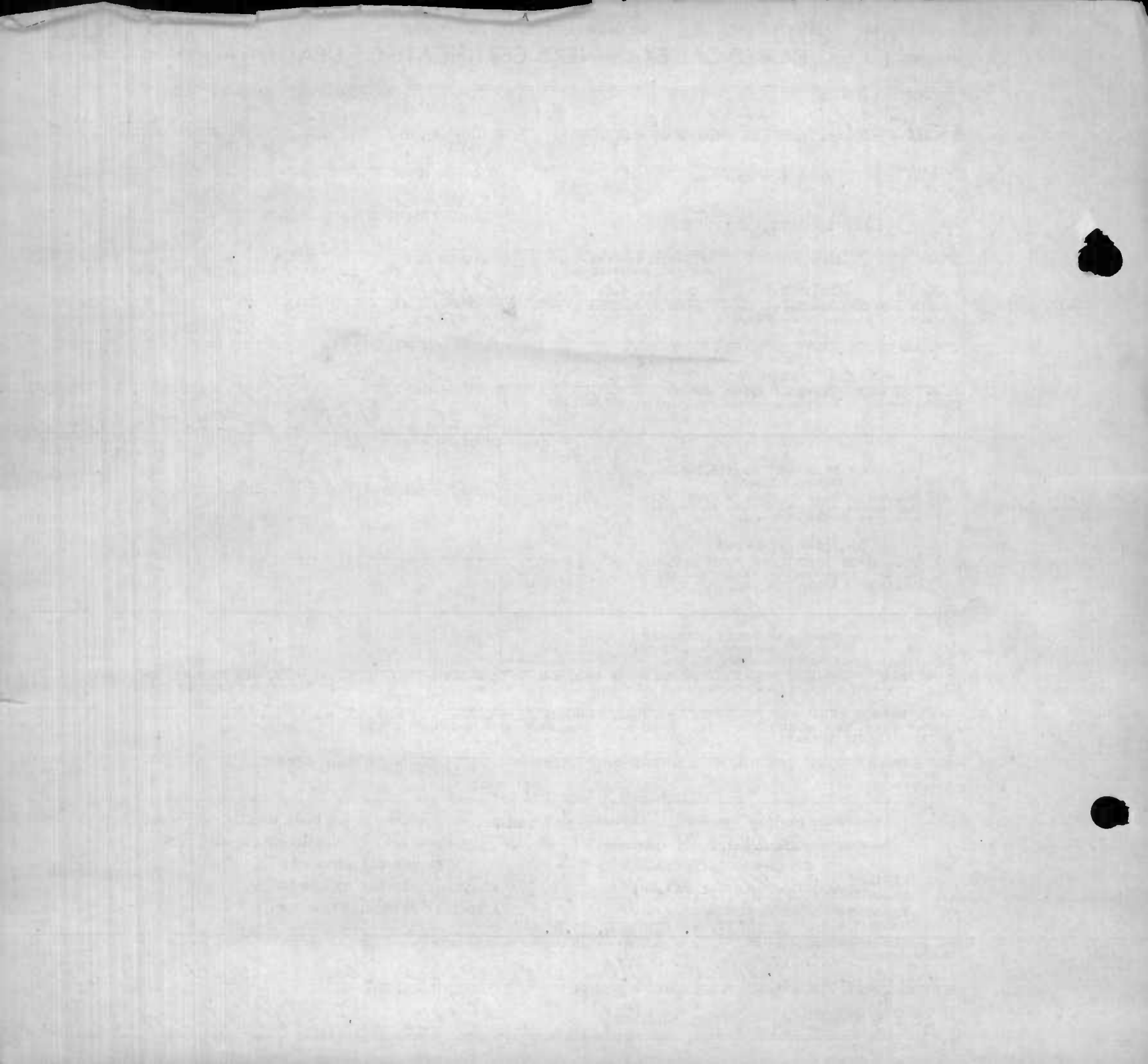
24C. FUNERAL DIRECTOR

ADDRESS

SEP 28 1965

Robert E. Fisher, M.D.

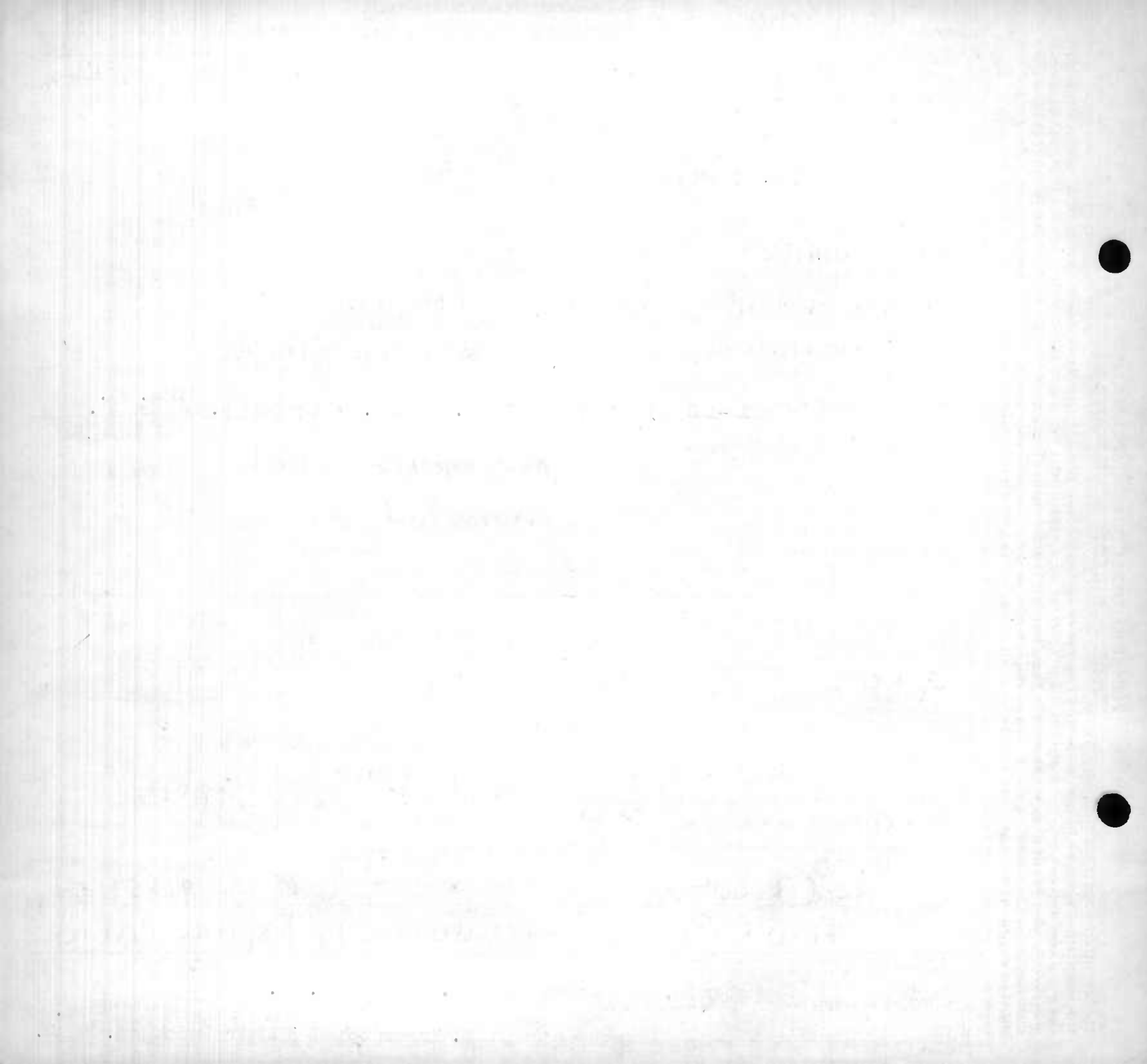
Orlington S. Phillips 1727 N. Mount St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

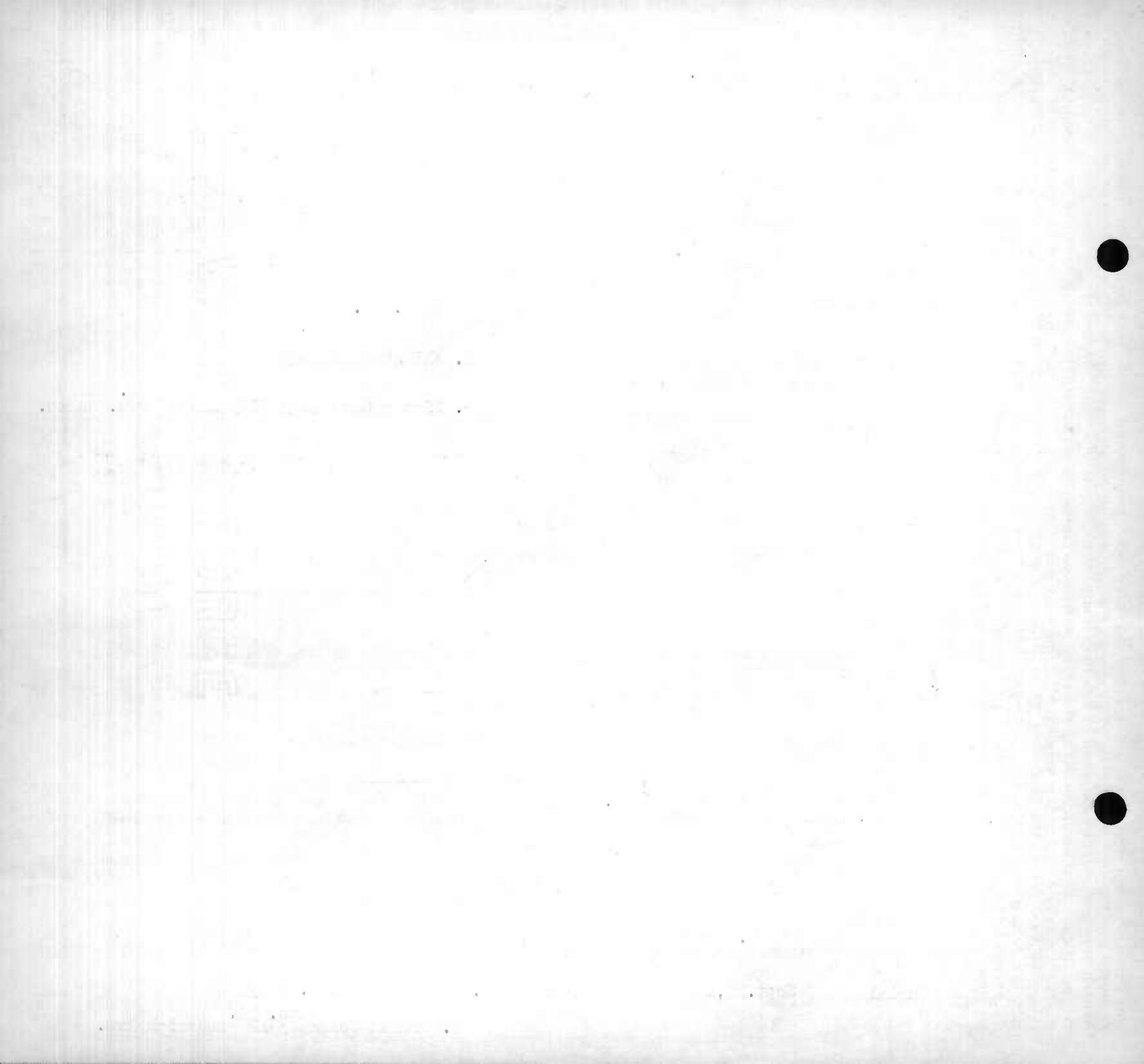
| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | Registered No. <u>31-75-21</u> | | | | |
| BIRTH NO. <u>65 9912</u> | | | | | 65 9912 | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Kelley, JAMES, LAMUEL.</u> | | | | | 2. DATE AND HOUR OF DEATH <u>Sept 25, 1965</u> <u>5¹⁰ A.M.</u> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND <u>UNIVERSITY HOSPITAL</u> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>BALTIMORE, MARYLAND.</u> | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND.</u> B. COUNTY <u>20-04</u> | | | | |
| 5. SEX <u>MALE</u> | | | | | 6. RACE <u>WHITE.</u> | | | | |
| 7. MARRIED, NEVER MARRIED WIDOWED <u>DIVORCED (specify)</u> <u>MARRIED.</u> | | | | | 8. DATE OF BIRTH <u>8/8/88</u> | | | | |
| 9. AGE (In years lost birthday) <u>77</u> | | | | | 10. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | | |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | | |
| 13. FATHER'S NAME <u>UNKNOWN James Kelley</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>REBECCA EILBURN.</u> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | | | 16. SOCIAL SECURITY NO. <u>UNKNOWN</u> | | | | |
| 17. INFORMANT <u>Mrs. Sadie B. Kelley 2414 W. Lombard St.</u> | | | | | ADDRESS <u>Balto. Md.</u> | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>420.1+1260X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Acute myocardial infarction.</u> | | | | | CAUSE OF DEATH (A) DUE TO <u>apox today.</u> | | | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ARTERIOSCLEROTIC VASCULAR DISEASE.</u> | | | | | (B) DUE TO <u>ARTERIOSCLEROTIC VASCULAR DISEASE.</u> | | | | |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Diabetes Mellitus.</u> | | | | | (C) DUE TO | | | | |
| 21. MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Diabetes Mellitus.</u> | | | | | 22. I certify that (I) (this hospital) attended the deceased from <u>Sept 24</u> 19 <u>65</u> to <u>Sept 25</u> 19 <u>65</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>Sept 25</u> 19 <u>65</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death. | | | | |
| 23A. SIGNATURE <u>Fred R. Eilber</u> | | | | | 23B. DATE SIGNED <u>9/25/65</u> | | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Fred R. Eilber.</u> | | | | | 23D. ADDRESS <u>UNIVERSITY HOSPITAL, BALTIMORE.</u> | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | | 24B. DATE <u>September 28, 1965</u> | | | | |
| 24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cem.</u> | | | | | 24D. LOCATION <u>Balto. Md.</u> | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | | 25B. NAME OF REGISTRAR | | | | |
| 25C. FUNERAL DIRECTOR <u>G. Truman Schwab 3512 Frederick Ave. Balto.</u> | | | | | ADDRESS Md. | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 65 9913 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|
| BIRTH NO. 65 9913 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) MRS. MACONACHY, MARION O. | | 2. DATE AND HOUR OF DEATH 9-24-65 6:45 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL | | (If not in hospital or institution, give street address or location) | | A. STATE MARYLAND | | B. COUNTY BALTIMORE | |
| 5. SEX F | | | | 6. RACE W | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | | 8. DATE OF BIRTH 2-12-90 | | 9. AGE (In years lost birthday) 75 | |
| 11. BIRTHPLACE (State or foreign country) Balto. Md. | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Wallace Owings | |
| 14. MOTHER'S MAIDEN NAME M. Elizabeth Dorsey | | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT W. Victor Maconachy | | | | ADDRESS Md. 21229 | | 18. CAUSE OF DEATH | |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | (A) ACUTE MYOCARDIAL INFARCTION 12 days | | | |
| 20. ANTECEDENT CAUSES | | | | (B) ASCVD | | | |
| 21. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) HYPERTENSIVE CVD | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | OBESITY | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| NONE | | NO | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 20, 1965 to Sept. 24, 1965, that (I) (we) last saw the deceased alive on Sept 24, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Charles S. Harrison | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-24-65 | |
| 23C. PHYSICIAN'S NAME (Type) Charles S. Harrison | | | | 23D. ADDRESS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE Sept. 28, 1965 | | 24C. NAME of CEMETERY or CREMATORY New Cathedral Cem. | | 24D. LOCATION (City, town, or county) Balto. Maryland (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR Balto. Md. G. Truman Schwab | | ADDRESS 3512 Frederick Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9914 | | BALTIMORE CITY CITY OF DEATH | | Registered No. 65 9914 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Frederick J. Schneider | | 2. DATE AND HOUR OF DEATH 9/23/65 6:07 pm M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 27-18 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital of Baltimore | | D. STREET ADDRESS (If rural, give location) 3223 W Garrison AVE. | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 7/18/83 | 9. AGE (in years last birthday) 82 | 10. CITIZEN OF WHAT COUNTRY? MD |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEAMFITTER- RET. | | 10B. KIND OF BUSINESS OR INDUSTRY CONTRACTING | | 11. BIRTHPLACE (State or foreign country) MD | |
| 13. FATHER'S NAME ANDREW SCHNEIDER | | 14. MOTHER'S MAIDEN NAME MARY | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Joseph F. Schneider - 8212 Wilson Ave | |
| 18. 443X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO CVA (B) DUE TO HASCD (C) | | INTERVAL BETWEEN ONSET AND DEATH 5 days Years | |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. GI bleed | | | | | |
| 19A. DATE OF OPERATION D | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (1) (this hospital) attended the deceased from 9/18/65 to 9/23/65, that (1) (we) last saw the deceased alive on 9/23/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Harry Tabor | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/23/65 | |
| 23C. PHYSICIAN'S NAME (Type) HARRY TABOR | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-27-65 | | 24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cem. | |
| 24D. LOCATION Baltimore, Md. | | 24E. LOCATION (City, town, or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | 25B. NAME OF REGISTRAR Robert E. Tabor | | 25C. FUNERAL DIRECTOR Joseph Conroy | |
| | | | | ADDRESS F. W. - Catonsville, Md. | |

FUNERAL DIRECTOR: IMPORTANT

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| BIRTH NO. 62-1276465 9915 | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 9915 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | Registered No. | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| DUFFANY, AMY LYNN | | SEPTEMBER 25, 1965 | | 6:55 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL BALTO. 29, MD. | | A. STATE MARYLAND B. COUNTY HOWARD | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) ELLICOTT CITY | | | |
| | | D. STREET ADDRESS (If rural, give location) 32 DOGWOOD DRIVE | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE | 8. DATE OF BIRTH 5-16-62 | 9. AGE (In years last birthday) 3 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME BRUCE DUFFANY | | 14. MOTHER'S MAIDEN NAME JUDY STEM | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT ST. AGNES RECORDS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) IRREVERSABLE SHOCK | | INTERVAL BETWEEN ONSET AND DEATH 6 HOURS | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) MARKED DEHYDRATION 12 HOURS | | | |
| | | (C) GASTROENTERITIS, PROBABLY VIRAL 48 HOURS | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (myself) attended the deceased from SEPTEMBER 25, 1965 to SEPTEMBER 25, 1965 , that (I) (we) last saw the deceased alive on SEPTEMBER 25, 1965 and that in (my) (our) (ap) (X) apianian death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Walter C. Lesky, M.D. | | 23B. DATE SIGNED 9-25-65 | | | |
| 23C. PHYSICIAN'S NAME (Type) WALTER C. LESKY, MD | | 23D. ADDRESS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-28-1965 | | 24C. NAME of CEMETERY or CREMATORY St. Johns | |
| 24D. LOCATION (City, town, or county) (State) Ellicott City, Md | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 65 9916 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------------------------------|---------------------------------------------|
| BIRTH NO. <i>Washington Co. Md. 9916</i> | | | | 1. NAME OF DECEASED (Type or Print) <i>Jeffrey Lynn Smith</i> | | 2. DATE AND HOUR OF DEATH <i>9-25-65 11230 P M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>Washington</i> | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>38 University Hospital</i> | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Hagerstown</i> | | | |
| | | | | D. STREET ADDRESS (If rural, give location) <i>236 Westside Ave.</i> | | | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Never married</i> | 8. DATE OF BIRTH <i>6/6/41</i> | 9. AGE (In years last birthday) <i>4</i> | If Under 1 Yr. Months: Days: Hours: Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? <i>USA.</i> |
| 13. FATHER'S NAME <i>David Patrick Smith</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Gloria Dean Shatzer</i> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | | 16. SOCIAL SECURITY NO. <i>—</i> | | 17. INFORMANT ADDRESS <i>Mother</i> | | |
| 18. <i>237X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | (A) <i>Respiratory FAILURE</i> DUE TO | | <i>2 hours</i> | |
| | | | | (B) <i>INCREASED INTRACRANIAL PRESSURE</i> DUE TO | | <i>2 MONTHS</i> | |
| | | | | (C) <i>MID BRAIN TUMOR</i> | | <i>5 months</i> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | <i>None</i> | | | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>8-13</i> 19 <i>65</i> to <i>9-25</i> 19 <i>65</i> , that <i>(I)</i> (we) last saw the deceased alive on <i>9-25</i> 19 <i>65</i> and that in <i>(my)</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>(I)</i> (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <i>Paul D. Meyer</i> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>9-25-65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>PAUL MEYER</i> | | | | 23D. ADDRESS M.D. <i>UNIV. Hosp. BALTO. MD</i> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i> | | 24B. DATE <i>9-28-65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>Cedar Lawn Mem. Gardens</i> | | 24D. LOCATION (City, town, or county) (State) <i>Hagerstown, Md.</i> | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 28 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Taylor</i> | | 25C. FUNERAL DIRECTOR <i>Minnich Funeral Home</i> | | ADDRESS <i>Hagerstown, Md.</i> | |

Jeffrey Lynn Smith

University Hospital

Mr W Moore Brown

Daniel Patrick Smith

no

None

Mr

Hagerman

333 Westside Ave

4/8/01

Gloria Jean Spitzer

Mother

USA

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

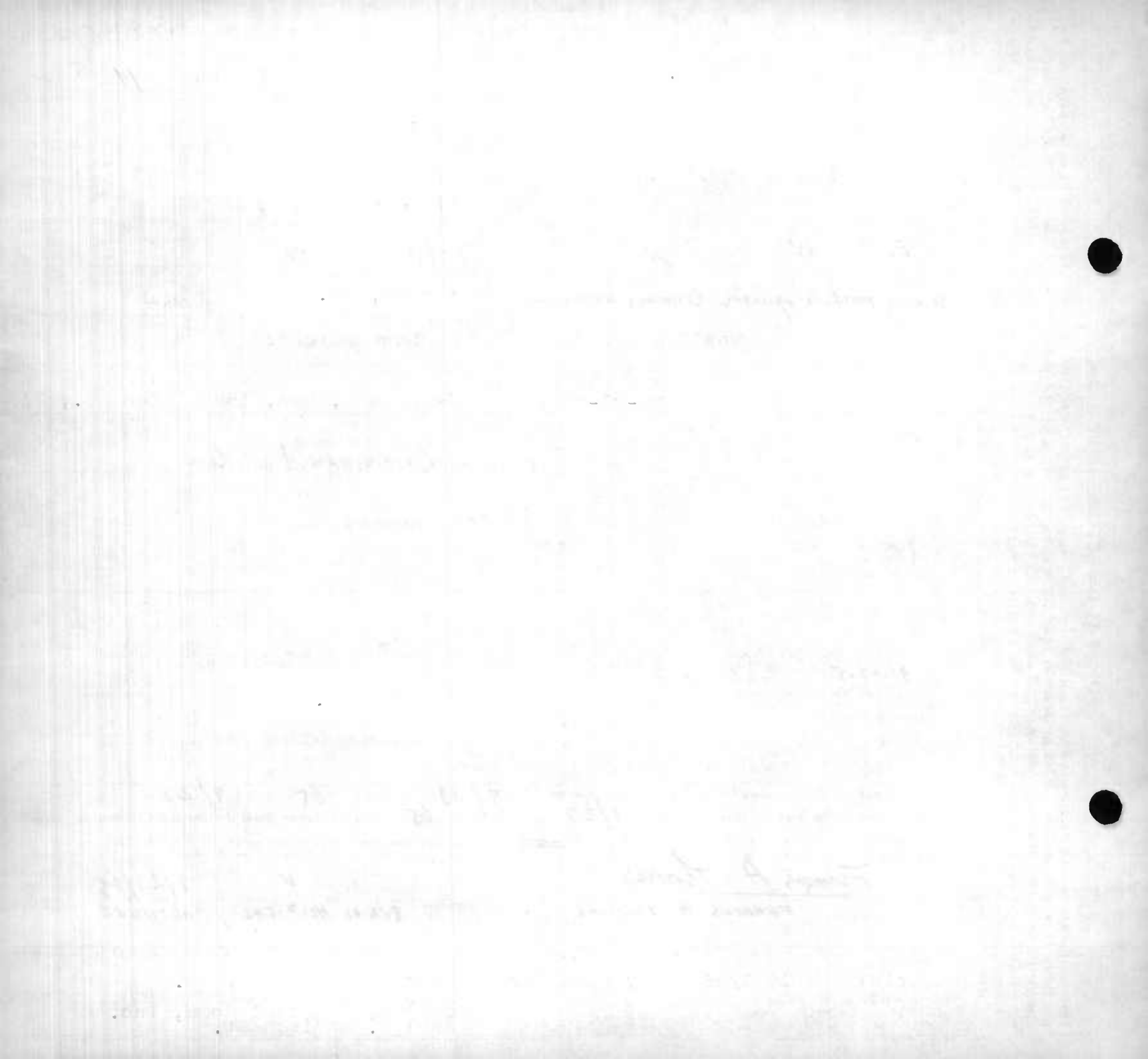
| BIRTH NO. | | 65 9917 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9917 | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|-----------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|----------------------------------------------------------------------|--------------------------|
| CERTIFICATE OF DEATH | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| ANNA MARIE BLANK | | | | Sept. 24, 1965 9:15 p. M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gould Nursing Home | | | | A. STATE Md., 21224 | | | |
| | | | | B. COUNTY 26-10 | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 134 S. Clinton St. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | If Under 1 Yr. Months Days Hours Min. | | If Under 24 Hrs. Min. |
| female | white | widowed | 11/2/1885 | 79 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| housewife | | at home | | Baltimore, Md. | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| John G. Suess | | | | Catherine Bayer | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| | | 220-46-8040 | | 3101 Shannon Drive John J. Suess, brother | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) DUE TO Cancer of Bladder (wound) | | 15 mos | |
| | | | | (B) DUE TO | | | |
| | | | | (C) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/22/1965 to 9/24/1965, that (I) (we) last saw the deceased alive on 9/22/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Benjamin Hirschstein | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9/24/65 | |
| 23C. PHYSICIAN'S NAME (Type) B. HIRSCHSTEIN | | | | 23D. ADDRESS 121 S. HIGHLAND AVE BALTIMORE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 9/28/65 | | Holy Redeemer Cemetery | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| SEP 28 1965 | | Robert E. Fink | | Schimunek Funeral Home, Inc. | | 3330 Brehms Lane | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 65 9918 | | CERTIFICATE OF DEATH | | Registered No. 65 9918 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-----------------------------|----------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED Sahm (Type or Print) COX MARY B. | | | | 2. DATE AND HOUR OF DEATH SEPT 27, 1965 11.25 A.M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 5300 D. STREET ADDRESS (If rural, give location) 159 Bladen Rd. #21 | | | | | |
| 5. SEX F. | 6. RACE W. | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) W | 8. DATE OF BIRTH 8/6/11 | 9. AGE (In years last birthday) 54 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) sewing machine operator | | | 10B. KIND OF BUSINESS OR INDUSTRY Gorman's Warehouse | | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Masilek | | | | 14. MOTHER'S MAIDEN NAME Lena Kutcher | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. 220-01-5237 | | 17. INFORMANT Nelson Sahm, son, 159 Bladen Rd., 21 | | | | |
| 18. 1750 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) OVARIAN CARCINOMA with metastasis DUE TO (B) Vernia, acidosis DUE TO (C) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 9/24/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ovarian carcinoma with involvement of uterus | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/19 1965 to 9/27 1965, that (I) (we) last saw the deceased alive on 9/27 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Francis A. Thomas | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/27/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) FRANCIS A. THOMAS | | | | 23D. ADDRESS SINAI HOSPITAL, BALTIMORE | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 10/1/65 | | 24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. | | | | ADDRESS 2601 E. Madison St. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

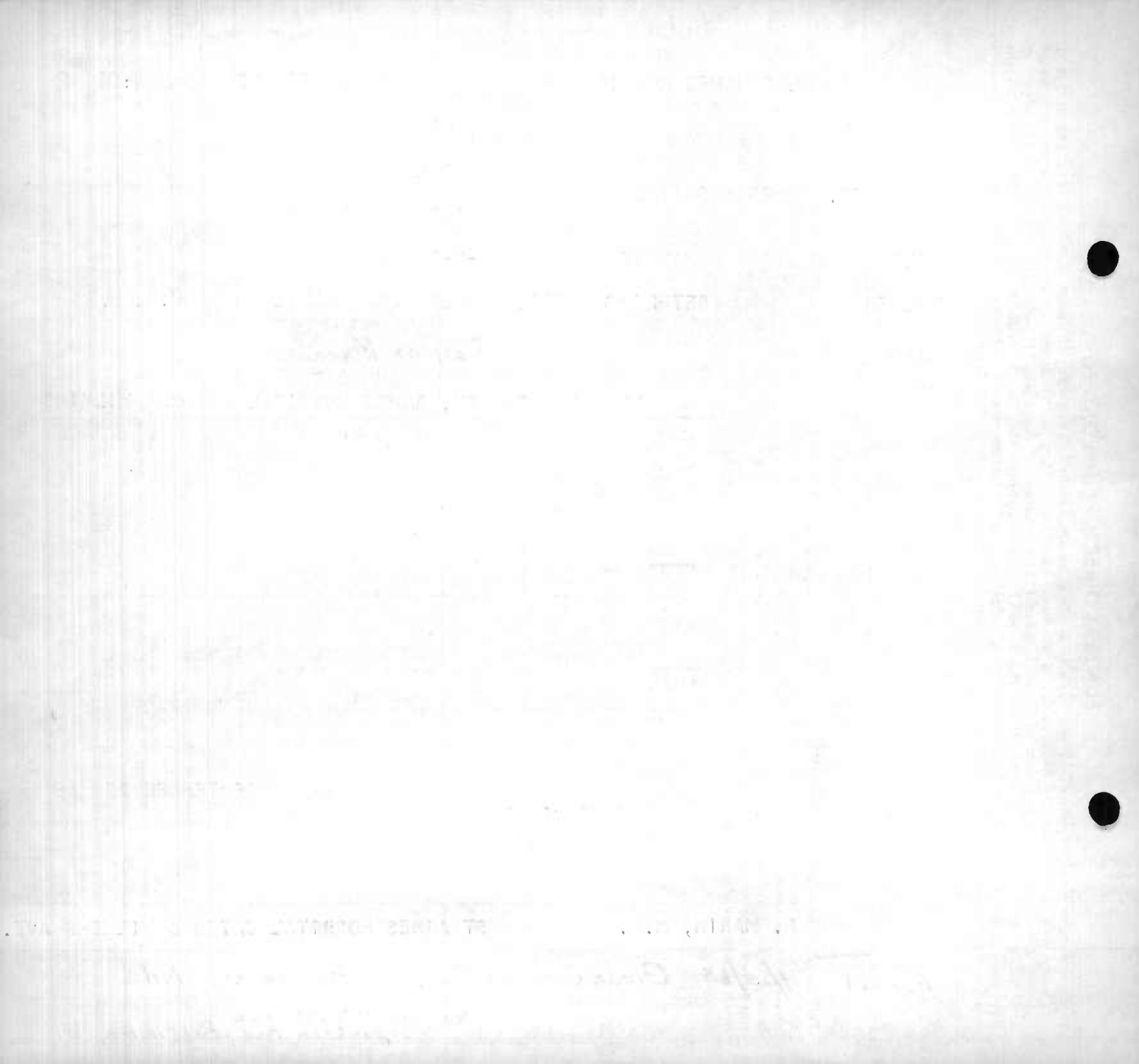
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|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|--------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------|--------------------------------|
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. | |
| M.E. CASE NO. | | 65 9919 | | 65 9919 | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| White, Anna Grace (Mrs. Robert E.) | | 9/19/65 | | 7:10 A.M. | |
| 3. PLACE OF DEATH IN | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| BALTIMORE, MARYLAND | | A. STATE Maryland | | B. COUNTY Cecil | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| The Union Memorial Hospital | | Perryville | | | |
| D. STREET ADDRESS (If rural, give location) | | Susquehanna Avenue | | 57-00 | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months Days |
| Female | White | Married | 3/19/09 | 56 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| House Wife | | | | Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Joseph B. White | | Beulah Todd | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | 212-30-1694 | | Mr. Robert E. White | |
| | | | | ADDRESS Same as above | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | (A) Metastatic Breast Carcinoma | | 3 years | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 9/13/19 65 to 9/19/19 65, that (2) (we) last saw the deceased alive on 9/19/19 65 and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| A. C. Tipton, Jr. | | | | 9/19/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| A. C. TIPTON JR | | The Union Memorial Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 9-22-1965 | | Asbury Cemetery | |
| 24D. LOCATION (City, town, or county) | | 24E. LOCATION (State) | | | |
| Port Deposit, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| SEP 28 1965 | | Cecil E. Farkner | | H. C. Patterson & Son, Perryville, Md. | |

U. S. T. 10. 11

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

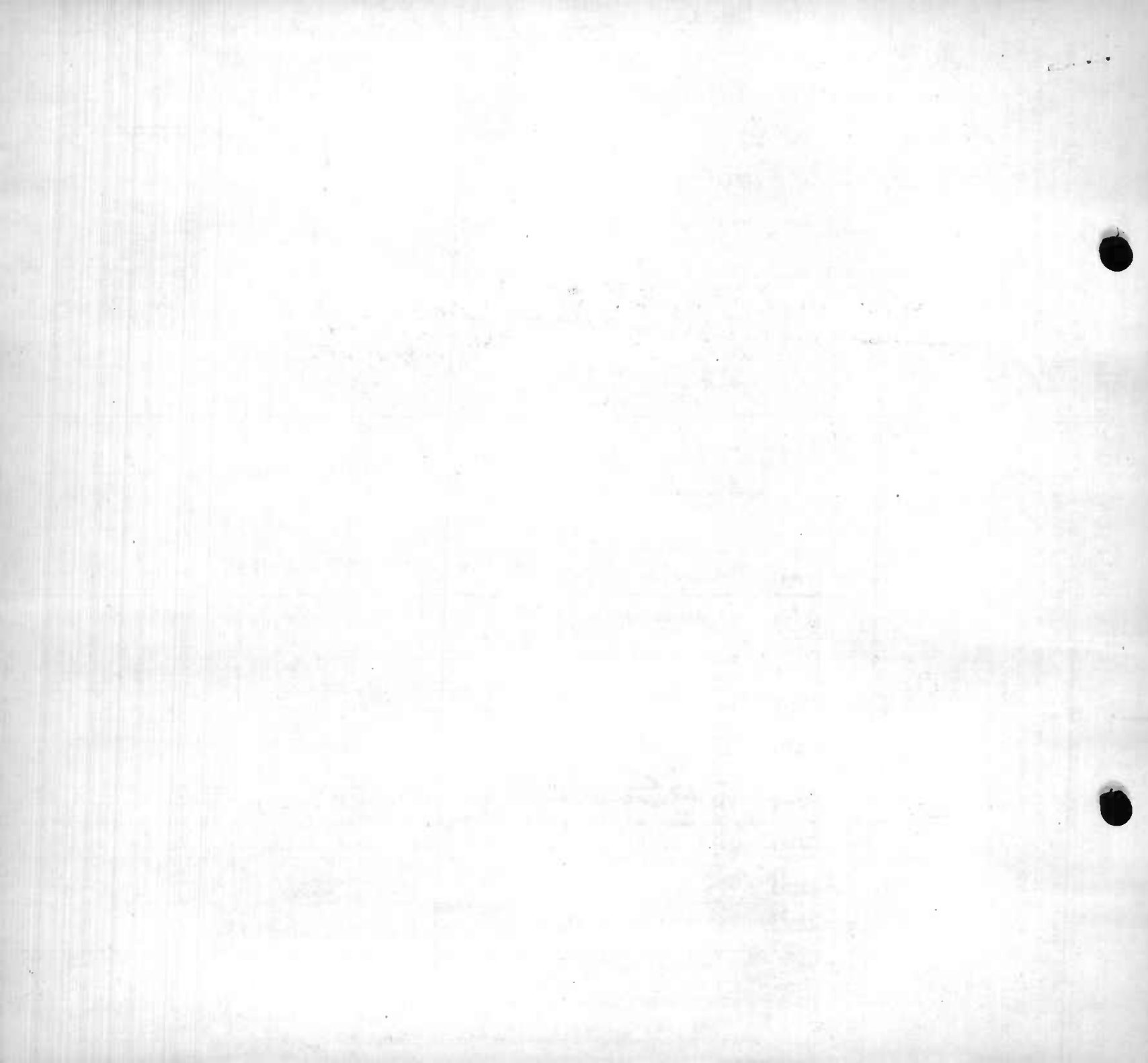
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|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. 65 9920 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9920 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) NICHOLAS JAMES MORRIS | | | 2. DATE AND HOUR OF DEATH SEPTEMBER 22, 1965 8:05 P M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balto C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 1729 MANOR ROAD | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 2-2-21 | 9. AGE (In years last birthday) 44 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WELDER | | 10B. KIND OF BUSINESS OR INDUSTRY BETHLEHEM STEEL | 11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S. |
| 13. FATHER'S NAME James | | | 14. MOTHER'S MAIDEN NAME Despina Markakis | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes or no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 217 01 8826 | 17. INFORMANT AND CATON AVENUE ADDRESS ST. AGNES HOSPITAL RECORDS WILKINS | | |
| 18. 442X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) glomerulonephritis type undetermined ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) Hypertrophy of the heart (B) Chronic heart failure (C) Metabolic acidosis | | CAUSE OF DEATH glomerulonephritis type undetermined | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from AUGUST 30 1965 to SEPTEMBER 22 1965 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on SEPTEMBER 22 1965 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (did not) view the body after death. | | | | | |
| 23A. SIGNATURE R. Marin | | | | 23B. DATE SIGNED 9/23/65 | |
| 23C. PHYSICIAN'S NAME (Type) R. MARIN, M.D. | | 23D. ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVE. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9/25/65 | 24C. NAME of CEMETERY or CREMATORY Greek Orthodox Cemetery | | 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | 25B. NAME OF REGISTRAR Robert E. Fisher | | 25C. FUNERAL DIRECTOR ADDRESS Nicholas T. Matthews 3021 Eastern Ave., Baltimore, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9921 | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 65 9921 | | CERTIFICATE OF DEATH | | DATE AND HOUR OF DEATH 9/26/65 - 5:40 A.M. | |
| M.E. CASE NO. | | 1. NAME OF DECEASED Harry Punt | | 2. DATE AND HOUR OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY 27-16 | |
| FULL NAME OF HOSPITAL OR INSTITUTION Ab Lutheran Hospital | | (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| | | | | D. STREET ADDRESS (If rural, give location) 4503 - Homer Ave. | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) divorced | 8. DATE OF BIRTH 7/15/98 | 9. AGE (In years lost birthday) 67 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Mgr. | | 10B. KIND OF BUSINESS OR INDUSTRY Service Station | | 11. BIRTHPLACE (State or foreign country) Cascade Ind. | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME Edward D. Punt | | 14. MOTHER'S MAIDEN NAME Mangella Harbough | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown | | 16. SOCIAL SECURITY NO. 213-10-7403 | | 17. INFORMANT Mrs. Margie A. Styrer, 4717 Homer Ave | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I | | CAUSE OF DEATH (A) DUE TO Myocardial Infarction (B) DUE TO Coronary Thrombosis (C) Coronary Artery Disease | | INTERVAL BETWEEN ONSET AND DEATH 6 hrs. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | H A S C V D. | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept. 26, 1965 to Sept. 26, 1965 , that (I) (we) last saw the deceased alive on September 26, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE R. Blackmon, M.D. | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/26/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS Lutheran Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-29-65 | | 24C. NAME OF CEMETERY or CREMATORY Bethel Church of God Cascade | |
| 24D. LOCATION (City, town, or county) (State) Cascade Ind. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | 25B. NAME OF REGISTRAR Robert E. Faldut | |
| 25C. FUNERAL DIRECTOR Loring Byers | | 25D. ADDRESS 8728 Liberty Rd | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------|-----------------------------|
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9922 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | X | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| John F. Loos Sr. | | 7/24/65 | | 6:40 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| Maryland General Hospital | | Maryland Baltimore | | Baltimore | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore | |
| | | D. STREET ADDRESS (If rural, give location) | | 6704 Windsor Mill Rd. | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days |
| M | W | Married | 10-5-89 | 75 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Retired | | Wholesale Produce | | Balto, Md. | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| John H. Loos | | Amelia DeHmar | | U.S. | |
| 15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. ADDRESS | |
| No | | [REDACTED] | | [REDACTED] | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| [REDACTED] | | Chronic Lymphocytic Leukemia | | 2 mos? | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Chronic Lymphocytic Leukemia | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 8/23/65 | | Partial bowel obstruction | | Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-16-65 to 9-24-65, that (I) (we) last saw the deceased alive on 9-24-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| [Signature] | | 9-24-65 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 9-27-65 | | Baltimore | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| SEP 28 1965 | | Robert E. Taylor | | Living Byers 8728 Interhy Road | |
| | | | | Randalltown, Md. | |

7

John F. Lee

Maryland General Hospital

M W Morris 1 10-2-87 22

Baltimore, MD

Annie D. Lee

Severely

John H. Lee

Chronic lymphocytic leukemia

5/22/87 Partial bowel obstruction

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Decayed D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9923 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|--------------------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 65 9923 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) YOUNG, FLORENCE A | | 2. DATE AND HOUR OF DEATH SEPTEMBER 26, 1965 2:40P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND ST. AGNES HOSPITAL FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) WILKEN & CATON AVES. BALTIMORE, MARYLAND 21229 | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO C. CITY OR TOWN (If outside city limits, write RURAL and give township) WOODSTOCK D. STREET ADDRESS (If rural, give location) OLD COURT ROAD | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH 12-31-89 | 9. AGE (In years last birthday) 85 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) FREDERICK, MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME JOHN DAVIS | | 14. MOTHER'S MAIDEN NAME | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT BALTIMORE, MD. ST. AGNES RECORDS-WILKEN & CATON AVES | |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9-19-1965 to 9-26-1965 , that (I) (we) last saw the deceased alive on 9-26-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Carmen Fratto</i> | | | | 23B. DATE SIGNED 9/26/65 | |
| 23C. PHYSICIAN'S NAME (Type) CARMEN FRATTO | | 23D. ADDRESS M.D. ST. AGNES HOSPITAL - WILKEN & CATON | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE Sept. 29, 65 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Olive | |
| 24D. LOCATION Randallstown, Balto., Co., Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | 25B. NAME OF REGISTRAR <i>Robert E. Farley</i> | |
| 25C. FUNERAL DIRECTOR <i>Forcing Byers 8728 Liberty Rd. Randallstown, Md.</i> | | 25D. ADDRESS | | | |

THE FOLLOWING

AT

THE HOTEL & HOUSE
SALT LAKE, UTAH

THE HOTEL & HOUSE

THE HOTEL & HOUSE

THE HOTEL & HOUSE

THE HOTEL & HOUSE

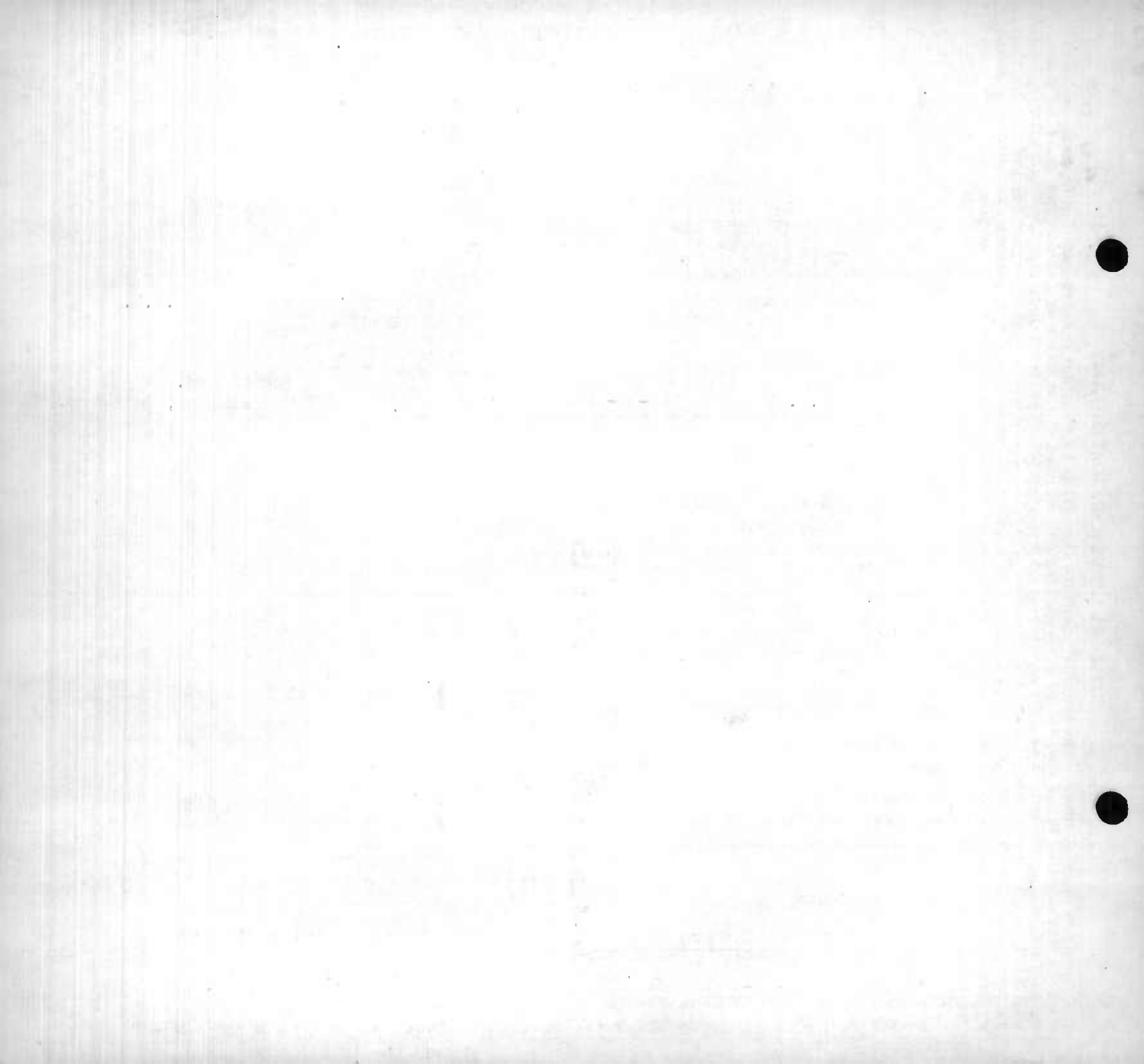
THE HOTEL & HOUSE

THE HOTEL & HOUSE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

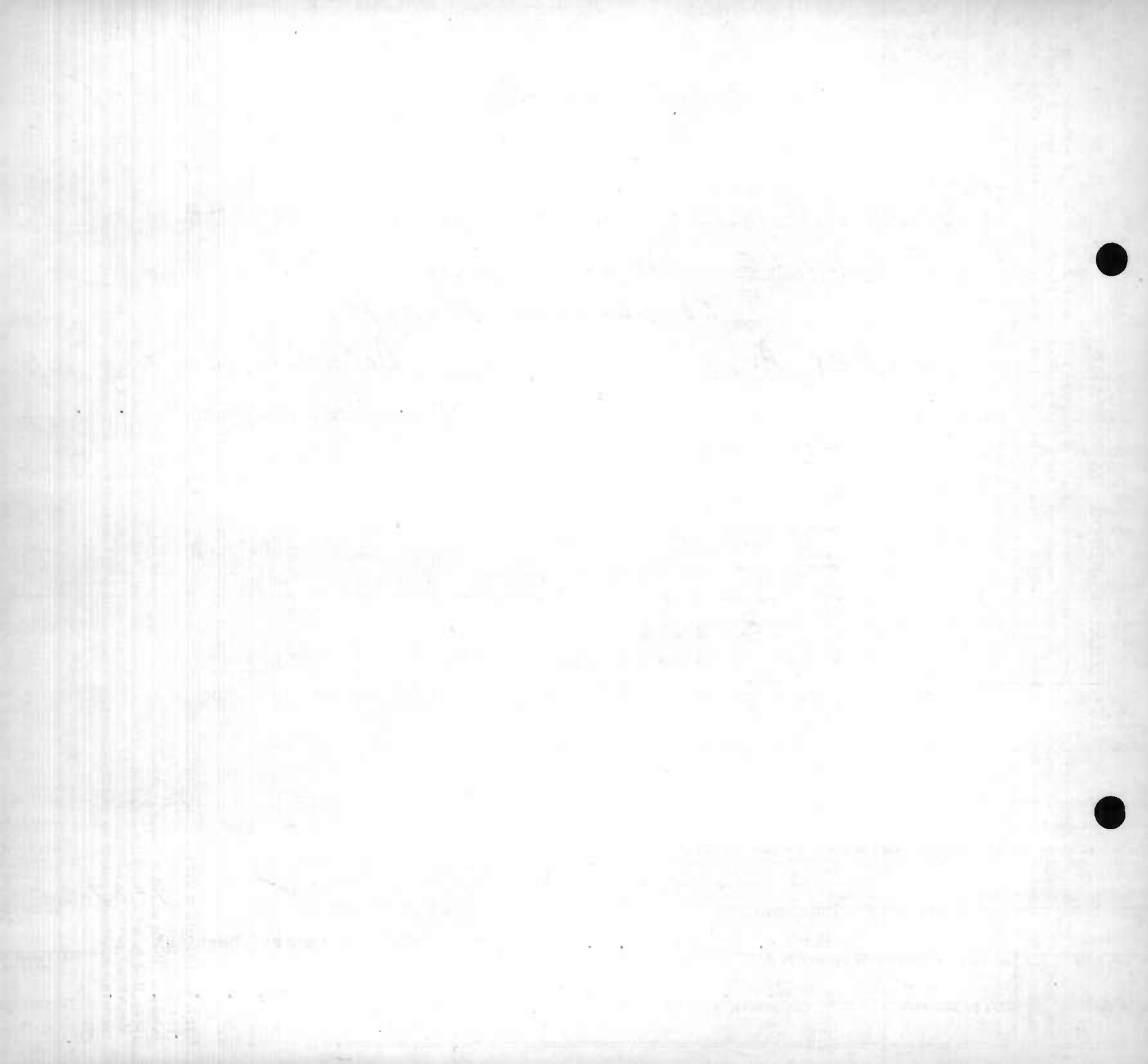
| | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|
| BIRTH NO. 65 9924 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65-9924 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) George R. Johnson | | | 2. DATE AND HOUR OF DEATH 9-23-65 11: 15am | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Delaware B. COUNTY Harrington C. CITY OR TOWN (If outside city limits, write RURAL and give township) Harrington D. STREET ADDRESS (If rural, give location) Weiner Avenue (Extended) | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 12-24-91 | 9. AGE (In years lost birthday) 63 73 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Penna. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 13. FATHER'S NAME Joseph Johanson | | |
| 14. MOTHER'S MAIDEN NAME Mary | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W. 1 212-07-6189 | | |
| 16. SOCIAL SECURITY NO. 212-07-6189 | | | 17. INFORMANT Weener Ave. Extended Hester E. Johnson Harrington, Delaware. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 162.1 I Aspiration DUE TO Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | CAUSE OF DEATH Aspiration DUE TO Branchogenic CA DUE TO Interval Between Onset and Death 3-4 hr. | | |
| 19A. DATE OF OPERATION 2 - | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED diagnostic curial neck biopsy | | 20A. AUTOPSY? (Yes or No) Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | |
| 21F. HOW DID INJURY OCCUR? | | 22. I certify that (I) (this hospital) attended the deceased from September 8, 1965 to September 23, 1965, that (I) (we) last saw the deceased alive on September 23, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | |
| 23A. SIGNATURE Charles T. Kaelber | | | 23B. DATE SIGNED 9/23/65 | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |
| 23C. PHYSICIAN'S NAME (Type) Charles T. Kaelber | | | 23D. ADDRESS The Johns Hopkins Hospital | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-27-1965 | | 24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery | |
| 24D. LOCATION Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Farber, M.D. | | 25C. FUNERAL DIRECTOR Frank J. Leitz | | 25D. ADDRESS 814 W 36th St Baltimore, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

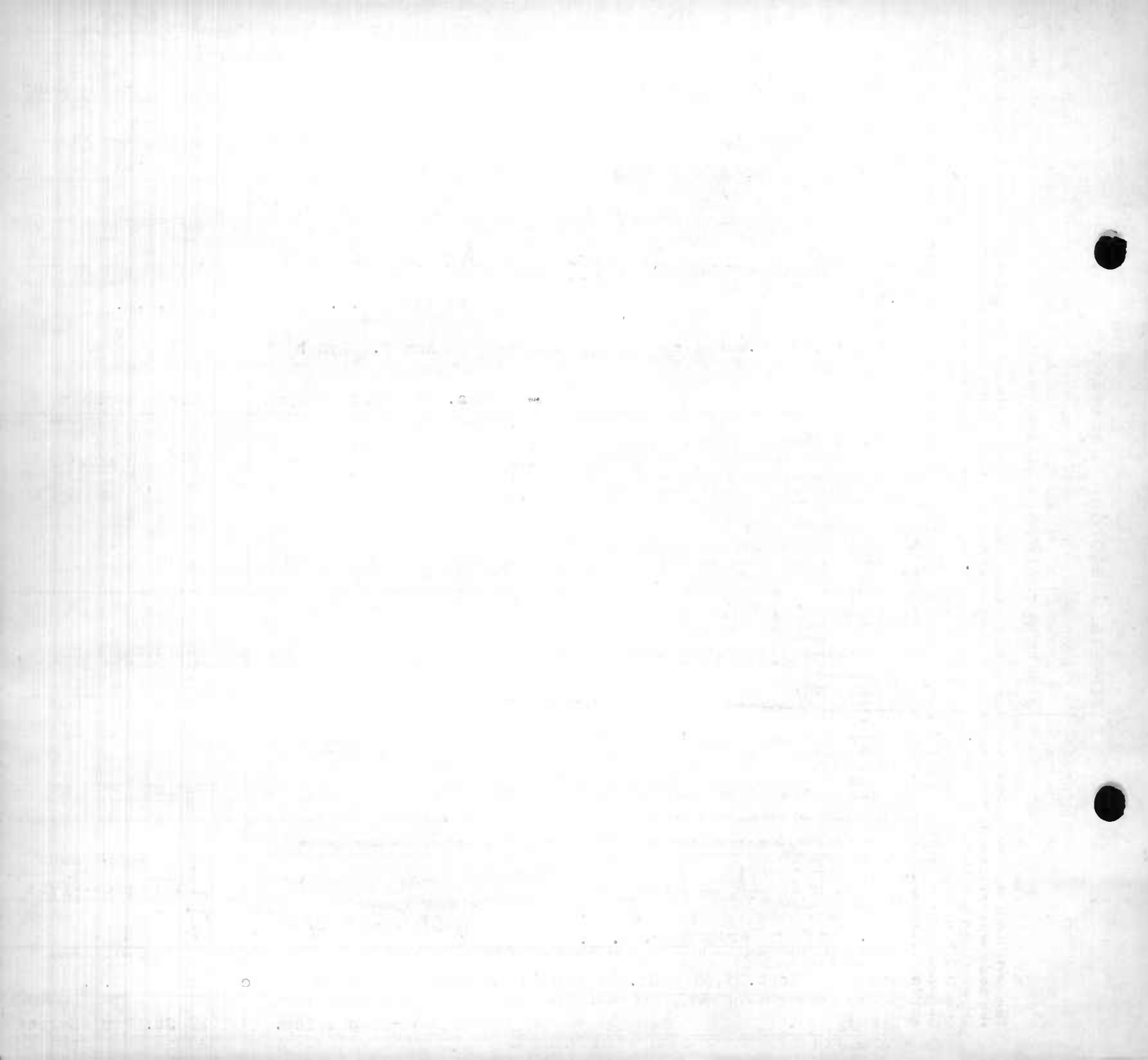
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9925 | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------|--|
| BIRTH NO. 65 9925 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Raines, Alice May | | 2. DATE AND HOUR OF DEATH 9-26-65 8:15 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 25-01 | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hosp | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #21225 | | | |
| 5. SEX F 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single | | 8. DATE OF BIRTH 8/21/1908 | | 9. AGE (In years last birthday) 57 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) I.B.M.-operator | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Walter A. | | 14. MOTHER'S MAIDEN NAME Dora C. Harding | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Robert L. Raines 3620 10th. St. | |
| 18. 331X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Intra cerebral Hemorrhage | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH approx. 8 hrs | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Essential Hypertension | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that the (this hospital) attended the deceased from 9-26 1965 to 9-26 1965 , that the (we) lost saw the deceased alive on 9-26 1965 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Hugh J. Hargrave M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 9-27-65 | |
| 23C. PHYSICIAN'S NAME (Type) Hugh J. Hargrave, M. D. | | 23D. ADDRESS South Baltimore General Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9 30 65 | | 24C. NAME OF CEMETERY or CREMATORY Cedar Hill | |
| 24D. LOCATION (City, town, or county) (State) Brooklyn, A. A. Co. Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Mc Cully | | ADDRESS 130 E. Fort Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

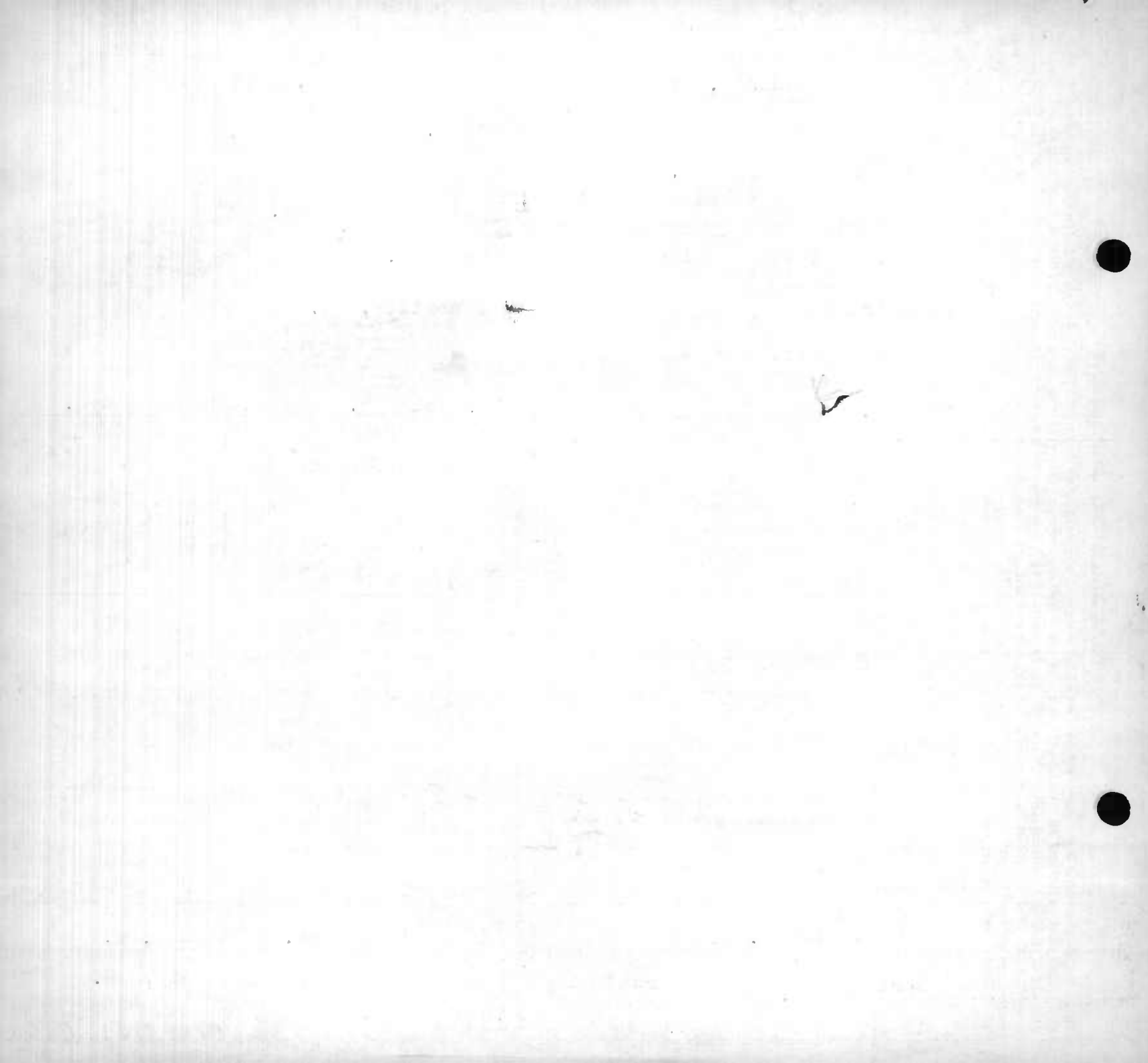
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9926 | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|-----------------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 65 9926 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Keiley, Miss ANNT. | | 2. DATE AND HOUR OF DEATH 9-24-65 1 55 PM | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 91 Keswick | | A. STATE Maryland B. COUNTY 13-07 | | | |
| (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 100 W. 40th | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH Nov. 6, 1882 | 9. AGE (In years last birthday) 82 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) New York, N.Y. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Cornelius C. Keiley | | 14. MOTHER'S MAIDEN NAME Ann T. Lynch | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mrs. Margaret O'Ryan Warren, Vermont | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 443X1 | | CAUSE OF DEATH (A) DUE TO Hypertensive Cardiac - Vascular Disease (B) DUE TO _____ (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH 3 years | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Apr. 11, 1963 to Sept. 24, 1965 , that (I) (we) last saw the deceased alive on Sept. 24, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE W. Grafton Hersperger | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED September 25, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) W. Grafton Hersperger, M. D. | | 23D. ADDRESS 700 West 40th St | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Removal | 24B. DATE Sept. 25, 65 | 24C. NAME OF CEMETERY OR CREMATORY St. Raymond's Cemetery | | 24D. LOCATION (City, town, or county) (State) Bronx New York, N.Y. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Wm Cook-Brooks, Inc. 1217 St. Paul Street | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9927 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|----------------------------------------------|
| BIRTH NO. 65 9927 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | Sadie T. Putsche (Nee North) | | Sept 26, 1965 | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 918 Evesham Ave. | | | A. STATE Md. | | |
| | | | B. COUNTY 27-48 | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | D. STREET ADDRESS (If rural, give location) | | |
| Baltimore | | | 918 Evesham Ave. | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| Female | White | Widowed | March 19, 1876 | 89 | 6 7 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Seamstress | | | | Cambridge, Md. | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Thomas North | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| no | | | | Mrs Zelma P. King 918 Evesham Ave. | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) Arteriosclerotic Cardia | | Years | |
| | | (B) Vascular Disease | | | |
| | | (C) Generalized Arteriosclerosis | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 14 Sept 1965 to 26 Sept 1965 , that (I) (we) last saw the deceased alive on 26 Sept 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Lauriston L. Keown | | | | 23B. DATE SIGNED 27 Sept 65 | |
| 23C. PHYSICIAN'S NAME (Type) Lauriston L. Keown | | | | 23D. ADDRESS 1938 Linden Ave. Baltimore, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 9/29/65 | | Druid Ridge | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. DATE REC'D BY HEALTH DEPT. | | | |
| Baltimore County, Md. | | SEP 28 1965 | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |
| SEP 28 1965 | | Robert E. Farley, M.D. | | 1913 W. Balt. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9928 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9928 | |
| M.E. CASE NO. | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) COWDER, Golan Albert | | | 2. DATE AND HOUR OF DEATH 9/24/65 12:35 a. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland, Baltimore B. COUNTY | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218 | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Randallstown | | |
| D. STREET ADDRESS (If rural, give location) 3002 Offutt Road | | | 5. SEX Male | | |
| 6. RACE Caucasian | | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | | |
| 8. DATE OF BIRTH 11/22/15 | | | 9. AGE (In years last birthday) 49 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | | 10B. KIND OF BUSINESS OR INDUSTRY Unknown | | |
| 11. BIRTHPLACE (State or foreign country) Morrisdale, Pennsylvania | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | |
| 13. FATHER'S NAME Maynard Cowder | | | 14. MOTHER'S MAIDEN NAME Grace Ruth Coble | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 3/15/41 to 12/7/45 | | | 16. SOCIAL SECURITY NO. 210-09-8565 | | |
| 17. INFORMANT Veterans Administration Hospital | | | ADDRESS 3900 Loch Raven, Blvd. Baltimore, Md. 21218 | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Bronchogenic Carcinoma with Metastases to Mediastinum, Brain and Liver | | | INTERVAL BETWEEN ONSET AND DEATH 3 months | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from September 3, 1965 to September 24, 1965 , that (X) (we) last saw the deceased alive on September 24, 1965 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (XXXX) view the body after death. | | | | | |
| 23A. SIGNATURE Robert W. Hamilton | | | | 23B. DATE SIGNED 9/24/65 | |
| 23C. PHYSICIAN'S NAME (Type) ROBERT W. HAMILTON | | | | 23D. ADDRESS VA HOSPITAL, 3900 Loch Raven Boulevard Baltimore, Maryland 21218 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-27-65 | | 24C. NAME OF CEMETERY or CREMATORY Mt. Pleasant Cemetery | |
| 24D. LOCATION Carroll Co. Md. | | 24E. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | 24F. NAME OF REGISTRAR Robert E. Fisher, M.D. | |
| 24G. FUNERAL DIRECTOR Harry W. Haight | | 24H. ADDRESS Sylacsville, Md. | | 24I. DATE SEP 28 1965 | |

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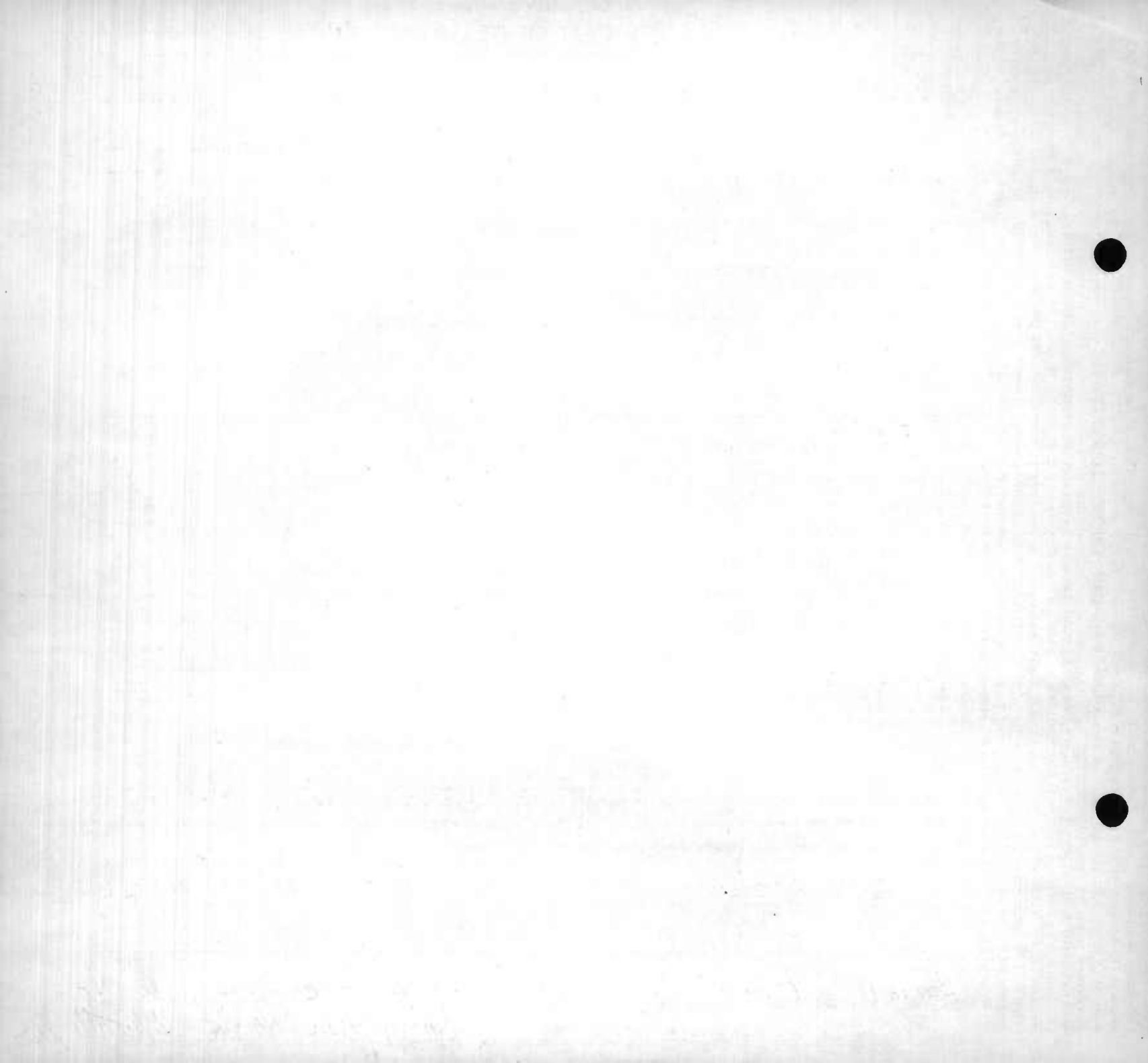
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9929 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9929 | |
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| 1. NAME OF DECEASED (Type or Print) MARY ELLEN BROWN | | | | 2. DATE AND HOUR OF DEATH Sept 24, 1965 5:45 AM | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 38 UNIVERSITY Hosp. | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE West Virginia B. COUNTY Greenspring C. CITY OR TOWN (If outside city limits, write RURAL and give township) V-45 D. STREET ADDRESS (If rural, give location) - | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 10-14-01 | 9. AGE (In years last birthday) 64 | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) West Va. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME George Robinson | | | 14. MOTHER'S MAIDEN NAME Mary Teeters | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) - | | | 16. SOCIAL SECURITY NO. - | | 17. INFORMANT Pt's husband. | | |
| 18. 55-0,11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Acute Renal Failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute Tubular Necrosis Shwartz 2° Peritonitis | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 16 days 22 days | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 9-2-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Perforated Appendix | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) - | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) - | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) - | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? - | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-8-65 to 9-24-65 , that (I) (we) last saw the deceased alive on 9-24-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="radio"/> (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE J C Hickey | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-24-65 | |
| 23C. PHYSICIAN'S NAME (Type) John C. Hickey | | | | 23D. ADDRESS University Hosp | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9-26-65 | 24C. NAME OF CEMETERY or CREMATORY Forest Glenn Cemetery | | 24D. LOCATION (City, town, or county) (State) Green Spring, W. VA. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | 25B. NAME OF REGISTRAR Robert E. Fink | | 25C. FUNERAL DIRECTOR Harry W. Knight | | | |
| ADDRESS Lykensville, Md. | | | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. | | | | Baltimore City Health Department | | Registered No. | |
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| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| 65-9930 | | | | BRANDENBURG, JESSE W. | | 9-23-65 11:45P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| 40 ST. AGNES HOSPITAL | | | | MARYLAND CARROLL | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | | | SYKESVILLE | | 56-00 | |
| | | | | D. STREET ADDRESS (If rural, give location) | | | |
| | | | | PULLEN NURSING HOME | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | |
| MALE | | WHITE | | WIDOWED | | 2-4-86 79 | |
| 9. AGE (In years lost birthday) | | 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| 79 | | | | | | MARYLAND | |
| | | | | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| JESS L. | | | | FLORENCE THOMAS | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | | | | | ST. AGNES RECORDS - CATON & WILKENS AVE. | |
| 18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | (A) Cerebral vascular accident | | 8-30-1965 | |
| | | | | DUE TO | | 9-23-1965 | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 0 | | | | NO | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from AUGUST 30 19 65 to SEPTEMBER 23 1965, that (I) (we) last saw the deceased alive on SEPTEMBER 23 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| Carl H. Matthey | | | | | | 9-24-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| CARL H. MATTHEY | | | | ST. AGNES HOSPITAL-CATON & WILKENS AVE | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 9-27-65 | | Woodlawn Cemetery | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | |
| SEP 28 1965 | | Robert E. Talbot | | Harry W. Haight | | Sykesville, Md. | |

ST. AGNES HOSPITAL

SALE WHITE THE OVEN

VEED L. 3334

FLORANCE THOMAS

ST. AGNES RECORDS - 27 JAN 1914

ST. AGNES RECORDS - 27 JAN 1914

ST. AGNES RECORDS - 27 JAN 1914

ST. AGNES RECORDS - 27 JAN 1914

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9931 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9931 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) HOOPER, ALICE | | | 2. DATE AND HOUR OF DEATH 9/21/65 4:20 a.m. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 16-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1638 W. Lanvale St., 17 | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 7-14-1887 | 9. AGE (In years last birthday) 78 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Unknown | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224 | |
| 18. 5-78X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Probable Aspiration DUE TO Gastro Intestinal Bleeding, Probable | | | INTERVAL BETWEEN ONSET AND DEATH 15 minutes 2 days | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | Arteriosclerotic Cerebral Vascular Disease with Congestive Heart Failure | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 11/18/64 to 9/21/65 and that (I) (we) last saw the deceased alive on 9-21-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Allen Johnson</i> | | | 23B. DATE SIGNED 9-21-65 | | |
| 23C. PHYSICIAN'S NAME (Type) ALLEN JOHNSON | | | 23D. ADDRESS 4940 Eastern Avenue, Baltimore, Maryland | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-25-65 | | 24C. NAME of CEMETERY or CREMATORY Sacred Hearts Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | 25B. NAME OF REGISTRAR <i>Charles R. Law</i> | | 25C. FUNERAL DIRECTOR ADDRESS Charles R. Law, 802 Madison Ave. | |

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

HERBERT JACKSON

2. DATE AND HOUR PRONOUNCED DEAD

9-27-65

3:35 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

LUTHERAN HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3019 Rayner Avenue 21216

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

6-15-1934

9. AGE (In years
last birthday)

31

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

GEN CONTRACTOR

11. BIRTHPLACE (State or foreign country)

SUSSEX CO VA

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

SAM JACKSON

14. MOTHER'S MAIDEN NAME

MARY AL KING

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

227-40-9861

17. INFORMANT

SAM JACKSON STONEY CREEK VA

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) Multiple stab wounds of chest
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

3019 Rayner Avenue

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
9 27 '65 1:35

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK21F. HOW DID INJURY OCCUR? Stabbed in chest with
pair of scissors by girl friend

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9-27-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

23B. DATE

9/28/65

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

Sussex Co VA

24A. DATE REC'D BY HEALTH DEPT.

SEP 28 1965

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

Maryland 21216 3019 Rayner Avenue SE

WALTON HOBBS

THE COURT

IN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

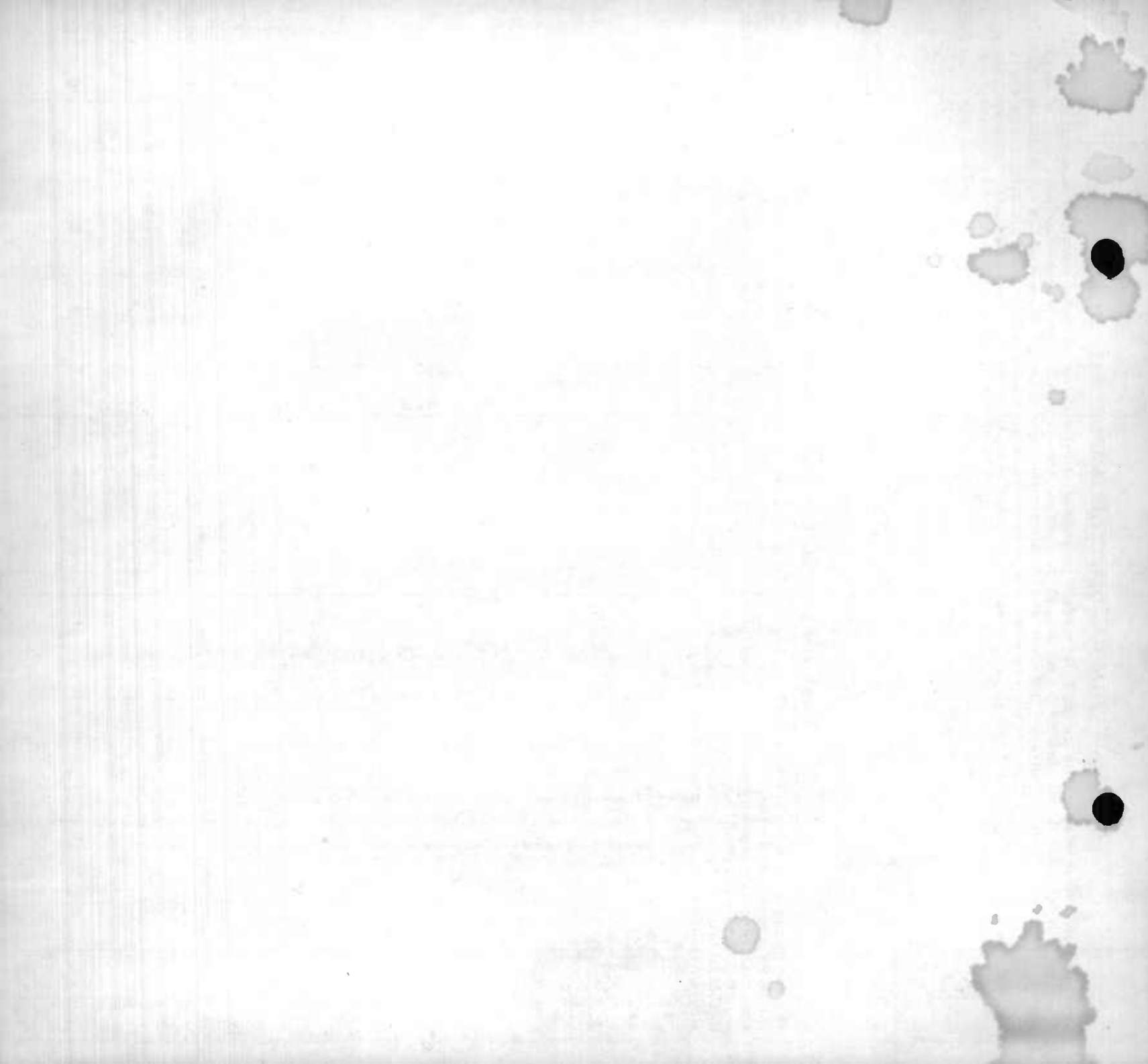
| BIRTH NO. 65 9933 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9933 | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------------------------------------------------------------------------------------------------|-----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Charles Ward | | | | 2. DATE AND HOUR OF DEATH 9-24-1965 3.20 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | | A. STATE B. COUNTY Maryland 25-32 | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | | D. STREET ADDRESS (If rural, give location) 2848 Booker Drive 2225 | | | |
| 5. SEX Male | 6. RACE Negro | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH 6-26-1879 | 9. AGE (In years last birthday) 86 | If Under 1 Yr. Months | If Under 24 Hrs. Days | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Minister | | | 10B. KIND OF BUSINESS OR INDUSTRY Ministry | | 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Thomas | | | 14. MOTHER'S MAIDEN NAME Sarah | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224 | | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) Respiratory Arrest DUE TO Acute Bronchitis (B) DUE TO (C) Bronchiectasis | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSE OF DEATH? YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-7-1965 to 9-24-1965, that (I) (we) last saw the deceased alive on 9-24-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE S.D. Kreider | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-24-1965 | |
| 23C. PHYSICIAN'S NAME (Type) S.D. Kreider | | | | 23D. ADDRESS M.D. 4940 Eastern Avenue, Baltimore, Maryland | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Cremation | | 24B. DATE 9/27/65 | | 24C. NAME of CEMETERY or CREMATORY Loudon Park Crematory | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR The Morton Dyett Funeral Home Inc | | ADDRESS 1701 Laurens St. Baltimore, Maryland | |

2002

FUNERAL DIRECTOR: IMPORTANT

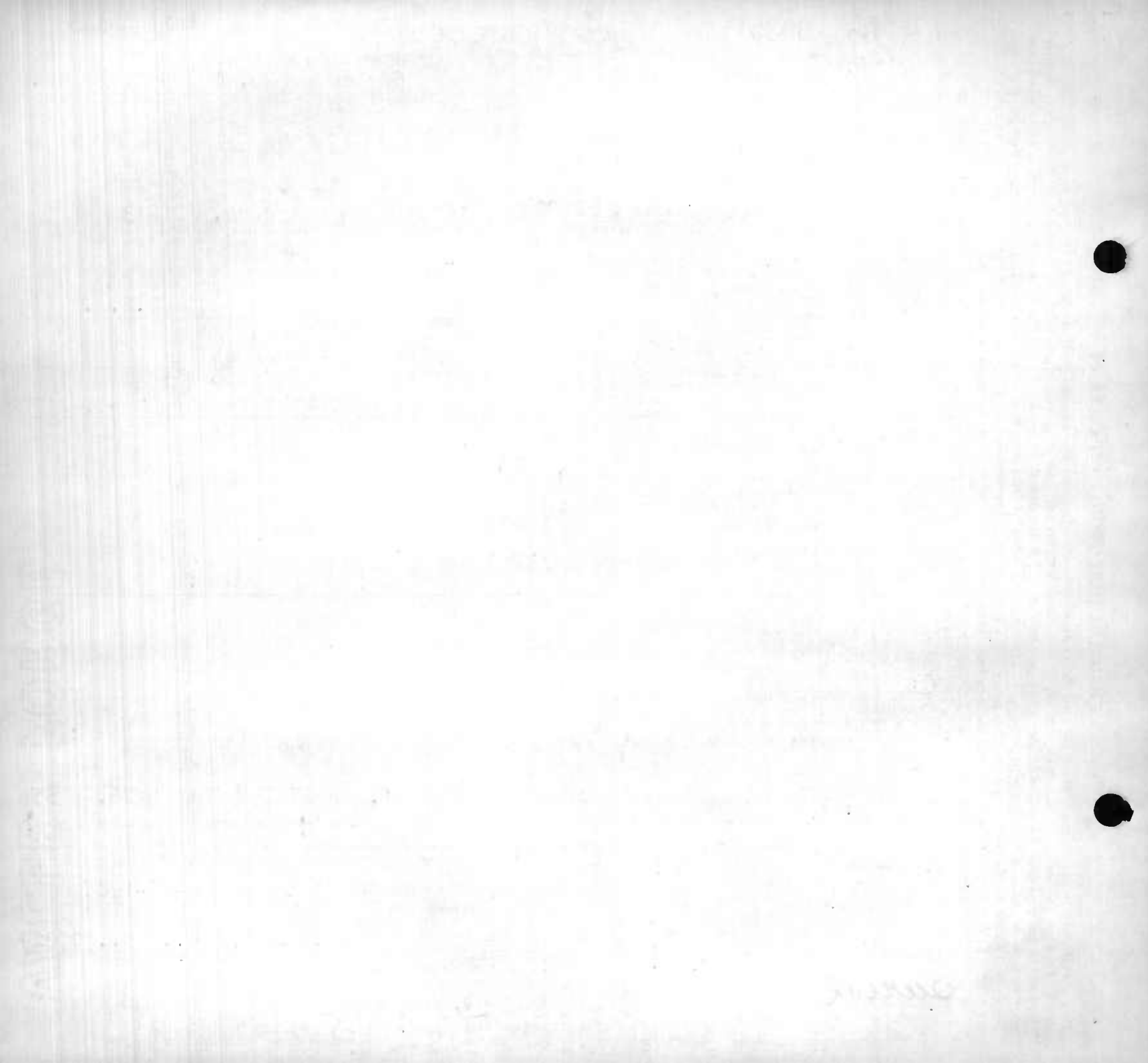
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9934 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9934 | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|------------------------------------------------------------------------|
| M.E. CASE NO. | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) THOMAS PENNISTON | | | 2. DATE AND HOUR OF DEATH 9/25/65 5:15 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived, if institutions; residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTO INC. | | | A. STATE MARYLAND B. COUNTY 27-16 | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | |
| | | | D. STREET ADDRESS (If rural, give location) 3215 WOODLAND AVE | | |
| 5. SEX MALE | 6. RACE NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE | 8. DATE OF BIRTH 8/12/1907 | 9. AGE (In years last birthday) 58 yrs | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME Caroline | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Mary Shirley 1962 Culpeper |
| | | | | | ADDRESS |
| 18. 153.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) RECTO SIGMOID CARCINOMA | | | CAUSE OF DEATH (A) RECTO SIGMOID CARCINOMA DUE TO | | INTERVAL BETWEEN ONSET AND DEATH KNOWN 9/24 - 9/25 |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) INTESTINAL OBSTRUCTION DUE TO | | 9/24 - 9/25 |
| | | | (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | RENAL FAILURE | | |
| 19A. DATE OF OPERATION 9/24/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED INTESTINAL OBSTRUCTION | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/23 1965 to 9/25 1965 , that (I) (we) lost saw the deceased alive on 9/25 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Jerome Paul Reichmister M.D. | | | | 23B. DATE SIGNED 9/25/65 | |
| 23C. PHYSICIAN'S NAME (Type) Jerome Paul Reichmister M.D. | | | | 23D. ADDRESS SINAI HOSPITAL OF BALTIMORE | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9-24-65 | | 24C. NAME of CEMETERY or CREMATORY New Cathedral | |
| 24D. LOCATION BALTO. | | 24E. LOCATION Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR MORTON + DYETT F.H. | |
| | | | | ADDRESS 1701 LAYRENS | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

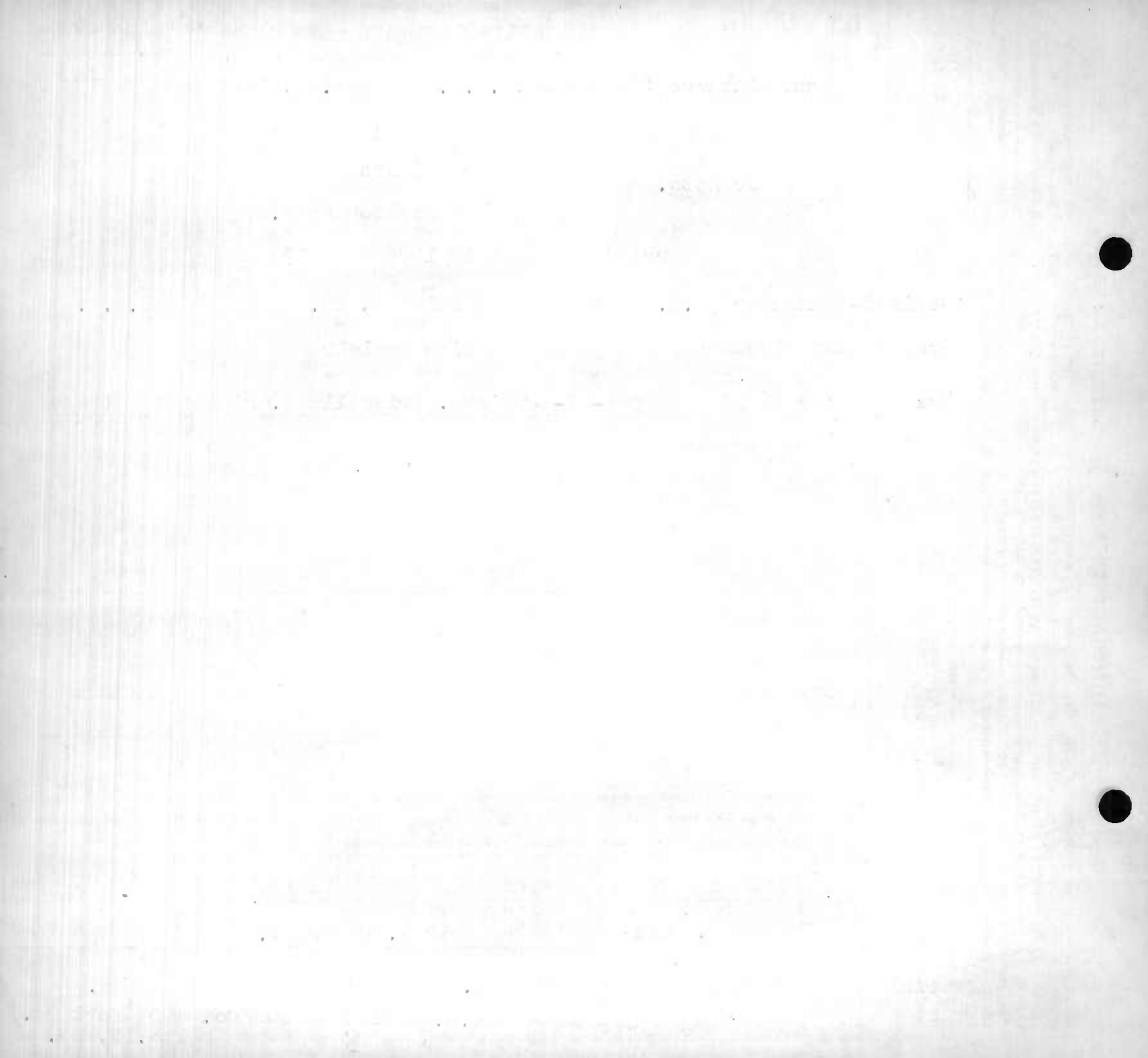
| BIRTH NO. 65 9935 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9935 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|------------------------------------------------------------------------------------------|--|------------------------|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| DOROTHY SCRIBER | | | | September 26, 1965 11:59 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland, #21224 | | | | Maryland Baltimore | | | |
| 5. SEX | | | | 6. DATE OF BIRTH | | | |
| Female | | | | 11-23-1912 | | | |
| 7. RACE | | | | 9. AGE (In years last birthday) | | | |
| Negro | | | | 52 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 11. BIRTHPLACE (State or foreign country) | | | |
| Semestic | | | | Maryland | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Arthur Tyler | | | | Mary Gray | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| | | | | | | | |
| 17. INFORMANT | | | | ADDRESS | | | |
| RECORDS: BCH, 4940 Eastern Ave., #21224 | | | | | | | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) Diabetes Mellitus | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) Heart Failure | | | |
| | | | | (C) Pulmonary Edema | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| | | | | | | | |
| 20A. AUTOPSY? (Yes or No) | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| No | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | |
| | | | | | | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | 21E. INJURY OCCURRED | | | |
| | | | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 21F. HOW DID INJURY OCCUR? | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from September 21, 1965 to September 26, 1965, that (I) (we) last saw the deceased alive on September 26, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Harry Dean Albert | | | | 9-26-1965 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| DR. HARRY DEAN ALBERT | | | | 4940 Eastern Ave., Balto., Md., #21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | | | 24B. DATE | | | |
| Burial | | | | 9/30/65 | | | |
| 24C. NAME OF CEMETERY OR CREMATORY | | | | 24D. LOCATION (City, town, or county) (State) | | | |
| Baltimore National Cem | | | | Balto Md | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | | | 25B. NAME OF REGISTRAR | | | |
| SEP 28 1965 | | | | Robert E. Farley, M.D. | | | |
| 25C. FUNERAL DIRECTOR | | | | ADDRESS | | | |
| Rayner Sanders | | | | 2176 Preston St | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

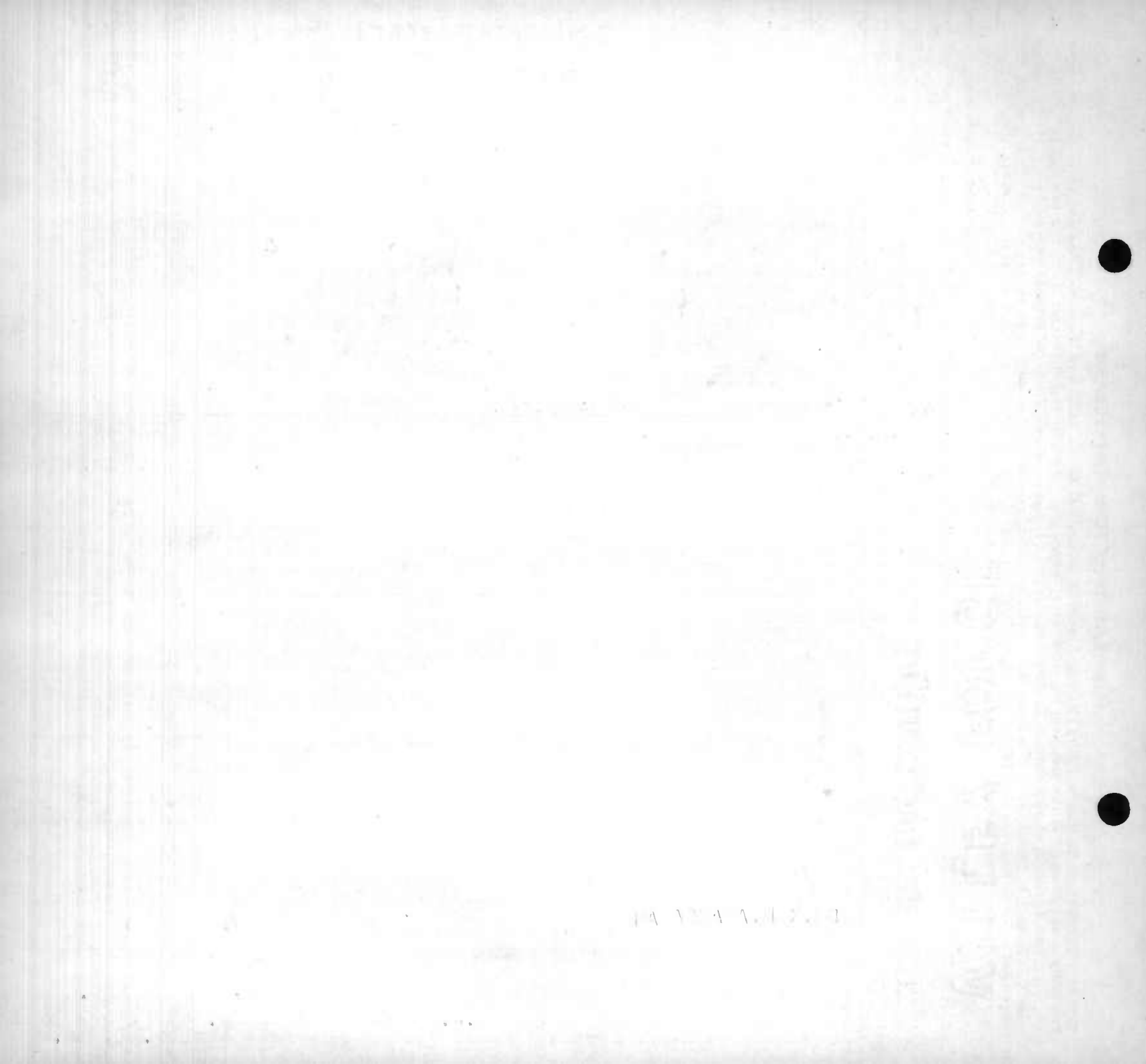
| BIRTH NO. 65 9936 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. 65 9936 | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------|--|----------------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | | | |
| Type or Print | | | | Evan Rinehart (Commander, U.S.N.) | | Sept. 27, 1965 | | 4 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence, before admission) | | A. STATE | | B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | | | If not in hospital or institution, give street address or location | | Maryland | | 3811 Center Street | |
| Ambassador Apts. | | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | Baltimore | |
| | | | | | | D. STREET ADDRESS (If rural, give location) | | 13-01 | |
| | | | | | | Ambassador Apts. | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | | 8. DATE OF BIRTH | | 9. AGE (In years lost birthday) | |
| M | | W | | Married | | 2/12/1886 | | 79 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Retired-Commander | | | | U.S. Navy | | Baltimore, Md. | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| Evan Thomas Rinehart | | | | Alice McBlair | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| Yes WWI & WW II | | | | 086-07-6697 | | Mrs. Priscilla P. Rinehart (Same) | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 153.8 I | | | | Carcinoma of Colon with Metastases to liver, etc. | | | | 3 years | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | Coronary Arteriosclerotic Heart Dis | | | | 10 years ± | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 0 | | | | No | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from DEC. 21 1963 to SEPT. 27 1965, that (I) (we) lost saw the deceased alive on SEPT. 26 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | | | |
| Robert W. Garis | | | | Sept. 27, 1965 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | |
| Robert W. Garis | | | | 12 W. Eager St. BALTIMORE, MD. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) | | (State) | |
| Burial | | 9/29/1965 | | Loudon Park Cem. | | Baltimore, Md. | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | |
| SEP 28 1965 | | Robert E. Taylor, M.D. | | H.W. Jenkins & Sons Co. | | 4905 York Rd. Balto. 12, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

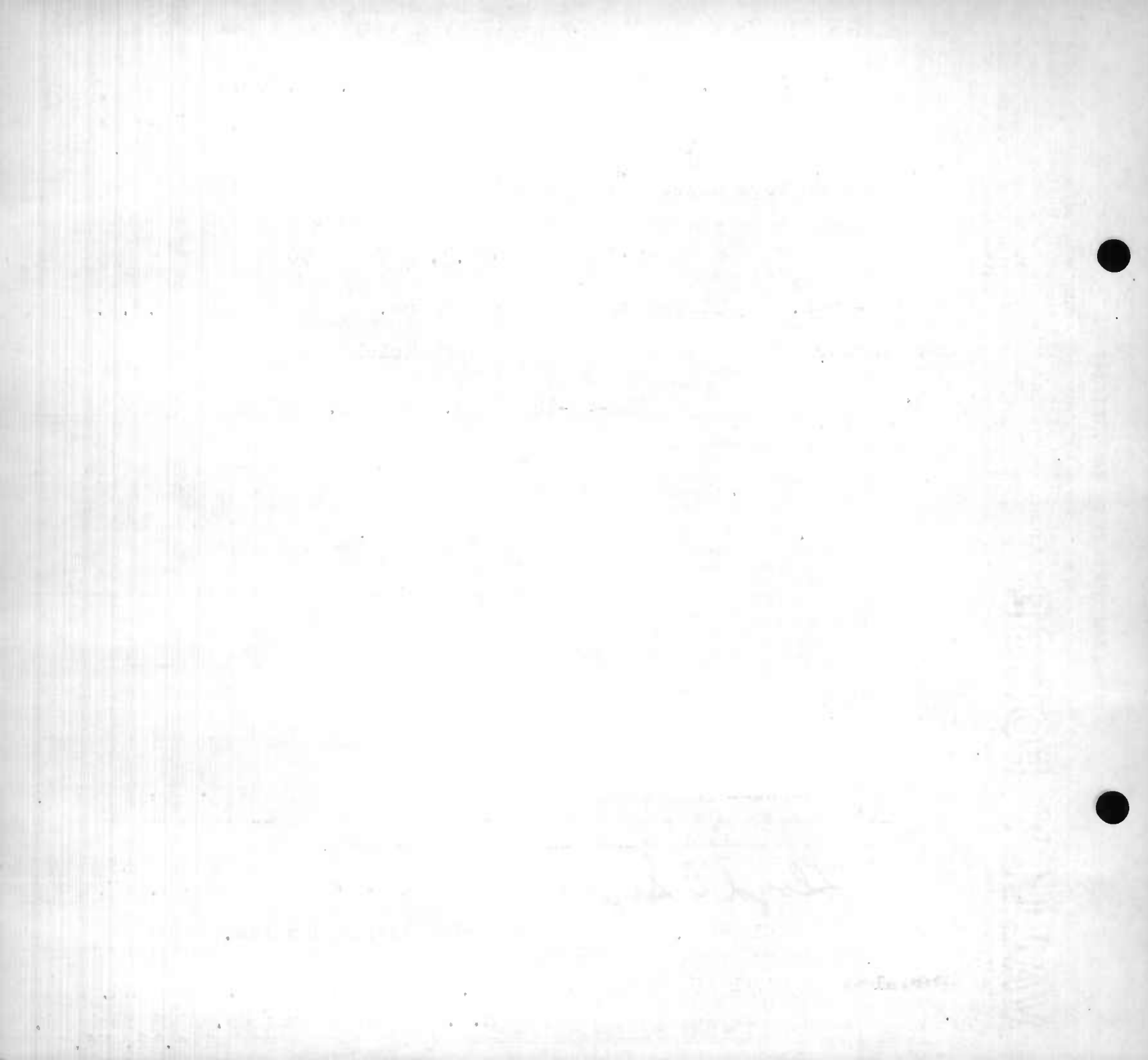
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------------|------------------------------|
| BIRTH NO. 65 9937 | | CERTIFICATE OF DEATH | | 65 9937 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | |
| (Type or Print) SPINDLER, GEORGE NMN (JR.) | | | | 9/26/65 7 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| Union Memorial Hospital | | Maryland | | Baltimore | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 609 Woodbourne ave. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. CITIZEN OF WHAT COUNTRY? |
| Male | White | Married | 1/17/96 | 69 yrs | U.S.A. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Supervisor, Ind. Eng. | | Good will ind. | | Maryland | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| George Spindler | | | Elizabeth Gleitsman | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 218-0576010 | | K.M. Anandiah Union Memorial Hospital | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 163 X I | | (A) Carcinoma of the | | October 1964 | |
| ANTECEDENT CAUSES | | (B) Lung, left, with metast | | to | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) Taxis, extensive | | Sept 26, 1965 | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| Death | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 2 | | | | Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 8/28 1965 to 9/26 1965, that (I) (we) last saw the deceased alive on 9/26 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| K.M. Anandiah | | | | 9/26/65 | |
| 23C. PHYSICIAN'S NAME (Type) DR. K. M. ANANDIAH | | 23D. ADDRESS | | | |
| K.M. ANANDIAH M.D. | | Union Memorial Hospital Baltimore | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 9/30/1965 | | Green Mount | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| SEP 28 1965 | | Robert E. Fisher | | H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. 65 9938 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------|------------------------------------------|--------------------------------------------------------------------------|-----------------------------|
| BIRTH NO. 65 9938 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | |
| | | | | John S. Taylor | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 2. DATE AND HOUR OF DEATH | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| 4 York Court | | Maryland | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 4 York Court | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | 10. Under 1 Yr. Months Days |
| M | W | Married | Oct. 4, 1874 | 90 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Cashier-Pres. | | Clifton Savings Bank Penna. | | U.S.A. | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| John Taylor | | | Sarah Welch | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS |
| No | | | 216-09-1481 | | Mrs. Helen A. Taylor (Same) |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | CAUSE OF DEATH | | |
| 422.1 I | | | Arteriosclerotic cardio-vascular disease | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | (A) DUE TO | | |
| ANTECEDENT CAUSES | | | (B) DUE TO | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (C) DUE TO | | |
| II | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| O | | | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) this hospital attended the deceased from January 19 62 to Sept. 26, 19 65, that (I) was last saw the deceased alive on September 22, 19 65 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Lloyd E. Saylor | | | | Sept. 27, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Lloyd E. Saylor | | 3902 Greenmount Ave. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| Burial | | 9/29/1965 | | Loudon Park Cem. | |
| | | | | Baltimore, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| SEP 28 1965 | | H.W. Jenkins & Sons Co. | | 4905 York Rd. Balto. 12, Md. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. **65 9939**

BIRTH NO. **65 9939**
M.E. CASE NO.
1. NAME OF DECEASED
(Type or Print) **WILLIAM HENRY HOOK**

2. DATE AND HOUR OF DEATH
9/28/65 4 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
UNION MEMORIAL HOSP.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **MARYLAND**
B. COUNTY **9-06**
C. CITY OR TOWN (If outside city limits, write RURAL and give township)
BALTIMORE
D. STREET ADDRESS (If rural, give location)
1634 CHILTON ST.

5. SEX **M.** 6. RACE **CAUC.** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) **MARRIED** 8. DATE OF BIRTH **9/16/1900** 9. AGE (In years lost birthday) **65** 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **BUS DRIVER** 10B. KIND OF BUSINESS OR INDUSTRY **BALTO TRANSIT CO BALTIMORE, MD** 11. BIRTHPLACE (State or foreign country) **USA** 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME **CHARLES HOOK** 14. MOTHER'S MAIDEN NAME **LEONA SMITH**

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) **NO** 16. SOCIAL SECURITY NO. **213-10-1245** 17. INFORMANT **MRS. KATHERINE V. HOOK (SAME)** ADDRESS

18. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
coronary arteriosclerotic heart disease
myocardial infarction, old, extensive
congestive heart failure
hypertension, etc. undetermined
poor
INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION **2** 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED **YES** 20A. AUTOPSY? (Yes or No) **YES** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from **9/20/1965** to **9/28/1965**, that (I) (we) last saw the deceased alive on **9/28/1965** and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE **Samuel C. Gresham** M.D. Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒ 23B. DATE SIGNED **9-28-65** 23C. PHYSICIAN'S NAME (Type) **Samuel C. Gresham** M.D. 23D. ADDRESS **Union Memorial Hosp.**

24A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **10/1/1965** 24C. NAME of CEMETERY or CREMATORY **Moreland Memorial** 24D. LOCATION (City, town, or county) (State) **Parkville, Balto. Co., Md.** 25A. DATE REC'D BY HEALTH DEPT. **SEP 28 1965** 25B. NAME OF REGISTRAR **Robert E. Farber, M.D.** 25C. FUNERAL DIRECTOR **H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.**

17-11-1944

200-1-1-1

17-11-1944

200

17-11-1944

BIRTH NO.

65 9940

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES C. DUNCAN

2. DATE AND HOUR PRONOUNCED DEAD

9-26-65

4:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

CHURCH HOME AND HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1916 E. Pratt Street 21231

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Nov 4 1927

9. AGE (In years
last birthday)

38

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Labor Cont

10B. KIND OF BUSINESS OR INDUSTRY

Armoco & Dranige Co

11. BIRTHPLACE (State or foreign country)

Lexington, Va.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Horace Duncan

14. MOTHER'S MAIDEN NAME

Emma Moore

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

World War II

16. SOCIAL
SECURITY NO.

223 30 6442

17. INFORMANT

William Duncan 1916 E Pratt Street

ADDRESS

18.

422.11

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

RUSSELL S. FISHER, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9-27-65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Sept 29 1965 Baltimore National Cem.

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

Frederick Road

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

SEP 28 1965

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

The Dippel Bros Inc 1800 E Lombard St

ADDRESS

5

2001 10 10 10:10

James Duncan
James Moore

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | | | | | | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|---------------------------------------------------|----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|--------------------------------------------|--|--|--|
| BIRTH NO. 64-21313 65 9941 5-4 16 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 9941 | | | | | |
| 1. NAME OF DECEASED (Type or Print) <u>Edwards, Alexander</u> | | | | | 2. DATE AND HOUR OF DEATH 9-27-65 5:30 A.M. | | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>The Johns Hopkins Hospital</u> | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>6-04</u> | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) <u>221 N. Washington Street</u> | | | | | | | | | | |
| 5. SEX <u>Male</u> | | 6. RACE <u>Negro</u> | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never Married</u> | | 8. DATE OF BIRTH <u>8-11-64</u> | | 9. AGE (In years lost birthday) <u>1</u> | | If Under 1 Yr. Months: Days: Hours: Min. | | | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baby</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | | | 11. BIRTHPLACE (State or foreign country) <u>Baltimore</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>Alexander Edwards</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Roberta Webb</u> | | | | | | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Roberta Alexander</u> | | | | | ADDRESS <u>221 N. Washington Street</u> | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac arrest</u> | | | | | CAUSE OF DEATH (A) <u>Cardiac arrest</u> DUE TO | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Chronic ascitis</u> | | | | | (B) <u>Chronic ascitis</u> DUE TO | | | | | <u>2 1/2 mo</u> | | | | | |
| | | | | | (C) <u>Hamantoma of liver</u> | | | | | <u>approx 3mo</u> | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Polypus of small bowel</u> | | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION <u>6/29/65</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Hamantoma Liver</u> | | | 20A. AUTOPSY? (Yes or No) <u>No</u> | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Chronic ascitis, polypus small bowel</u> | | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that <u>this hospital</u> attended the deceased from <u>8/24</u> 19 <u>65</u> to <u>9/27</u> 19 <u>65</u> , that (I) <u>lost</u> saw the deceased alive on <u>5:30 a.m 9/27</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>did</u> (did not) view the body after death. | | | | | | | | | | | | | | | |
| 23A. SIGNATURE <u>Jerry S. Dorman</u> | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | | 23B. DATE SIGNED <u>9/27/65</u> | | | | | |
| 23C. PHYSICIAN'S NAME (Type) <u>Jerry S. Dorman</u> | | | | | M.D. 23D. ADDRESS <u>The Johns Hopkins Hospital</u> | | | | | | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9-19-65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Int'l. City</u> | | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u> | | | | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 28 1965</u> | | | 25B. NAME OF REGISTRAR <u>Robert E. Taylor</u> | | | 25C. FUNERAL DIRECTOR ADDRESS <u>Calroy Wilson 2200 Bunting Ave</u> | | | | | | | | | |

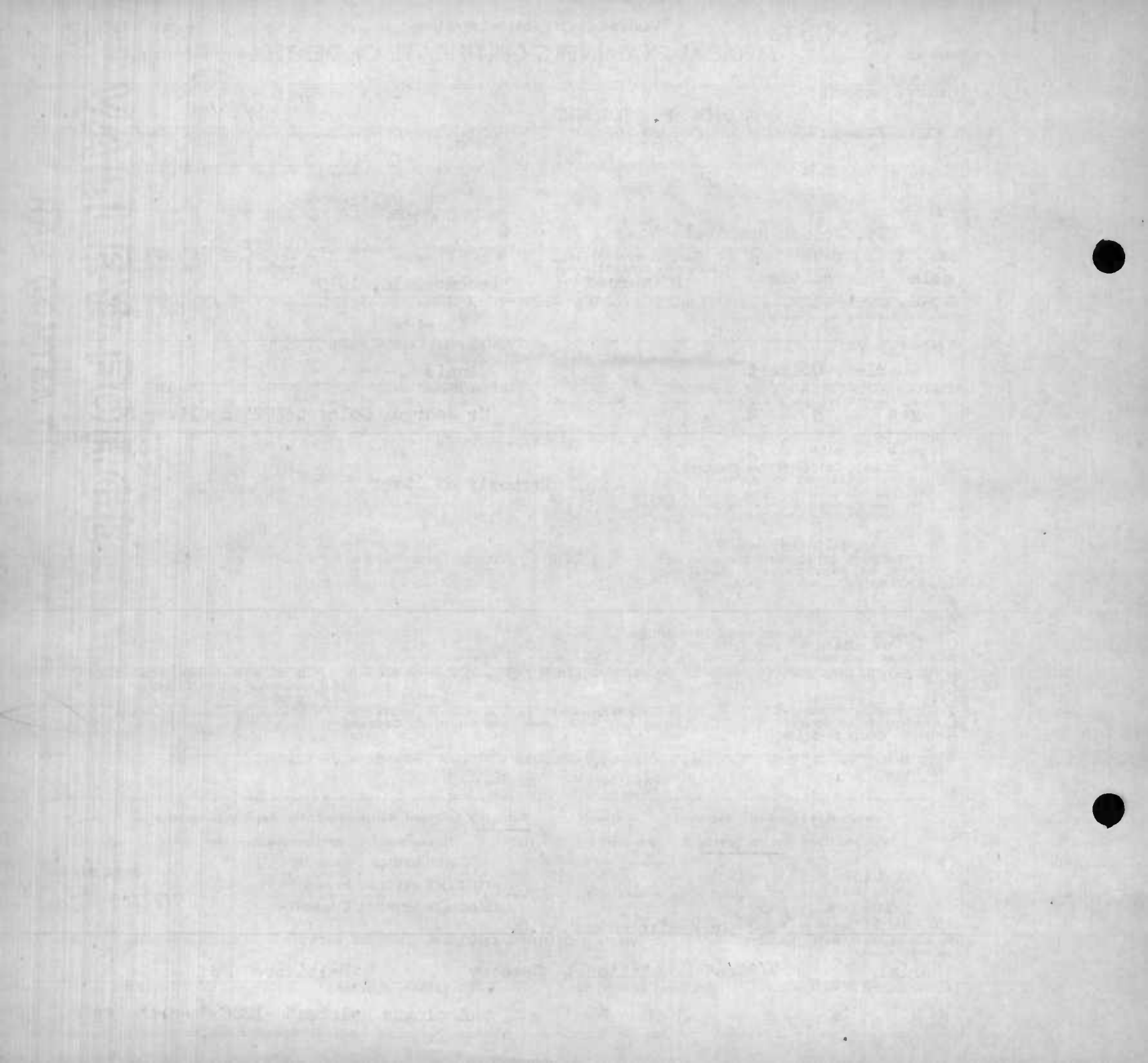
2015

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

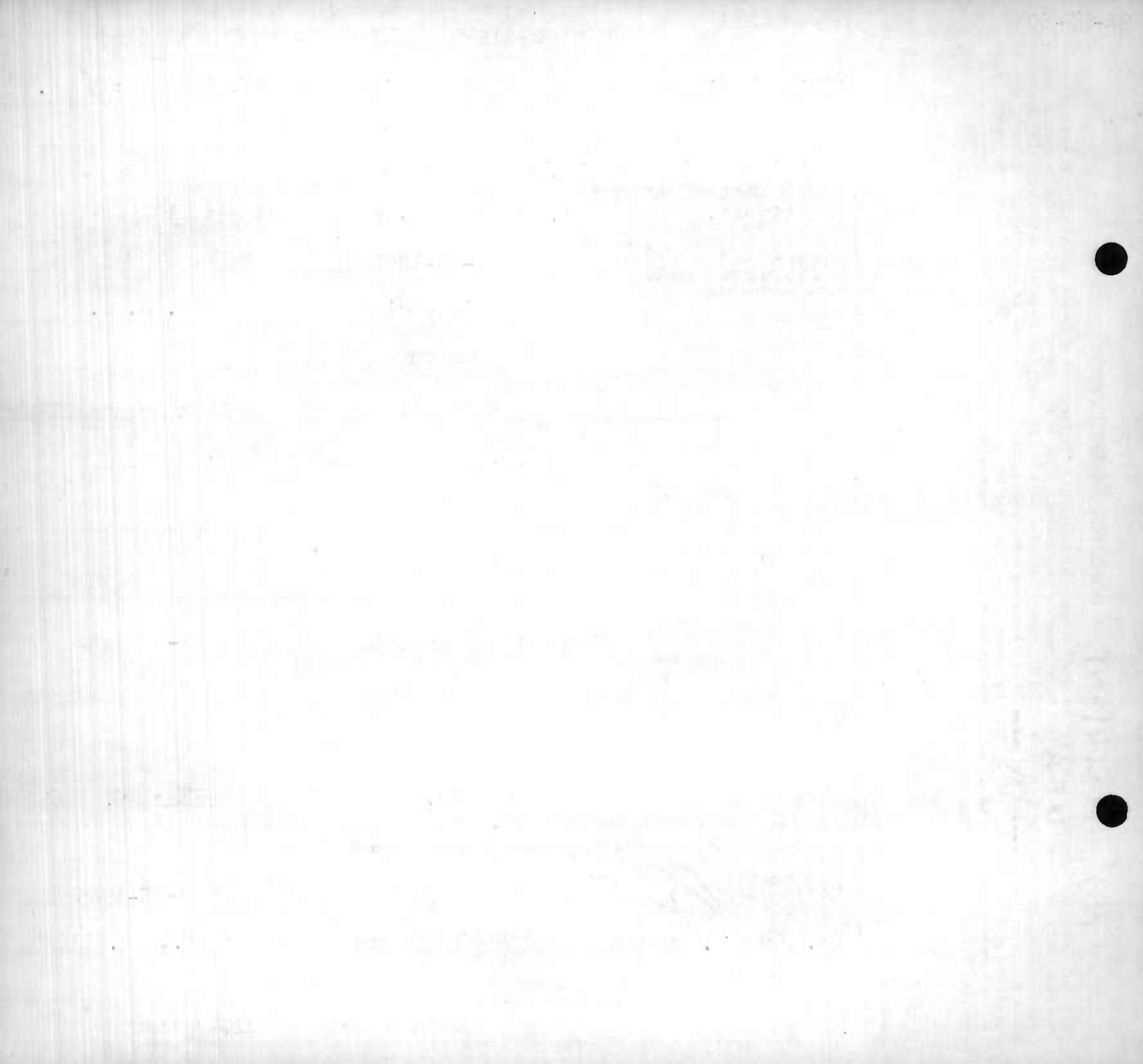
| | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 65 9942 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9942 | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) MILFORD JAMES LEE | | | 2. DATE AND HOUR OF DEATH Sept. 26, 1965 9:50 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital Wyman Pk. Drive & 31st Street | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 16-05 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2553 Arunah Ave. | | |
| 5. SEX M | 6. RACE col | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widower | 8. DATE OF BIRTH 6/12/09 | 9. AGE (In years last birth) 56 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deckhand | | 10B. KIND OF BUSINESS OR INDUSTRY Seafarer | | 11. BIRTHPLACE (State or foreign country) Va. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| 13. FATHER'S NAME Walter Lee | | | 14. MOTHER'S MAIDEN NAME Evie Curry | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 215-09-7911 | | 17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md. | |
| 18. 443X1 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pulmonary edema (A) DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cardiac hypertrophy and dilatation (B) DUE TO (Hypertension, clinical) (C) INTERVAL BETWEEN ONSET AND DEATH Days Months (Yrs) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 7 19 65 to Sept. 26 19 65, that (I) (we) last saw the deceased alive on Sept. 26 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Thomas J. Lau, Surgeon (R) | | | | 23B. DATE SIGNED 9/27/65 | |
| 23C. PHYSICIAN'S NAME (Type) Thomas J. Lau | | 23D. ADDRESS US PHS Hospital, Balto, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/30/65 | | 24C. NAME OF CEMETERY or CREMATORY FUNK Church Cem. | |
| 24D. LOCATION Northumberland Co. Va. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Farber, M.D. | | 25C. FUNERAL DIRECTOR George A. Kiser 1548 N. Calhoun St. | | | |

| 65 9943 | | BALTIMORE CITY HEALTH DEPARTMENT | | 65 9943 | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. | | | |
| M.E. CASE NO. | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | 2. DATE AND HOUR PRONOUNCED DEAD | | |
| BENJAMIN F. COLBERT | | | 9/26/65 8:30 a.m. | | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) | | | A. STATE Maryland | | |
| St. Joseph Hospital | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | | |
| | | | D. STREET ADDRESS (If rural, give location) 2724 E. Oliver St. | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| male | colored | Divorced | December 14, 1919 | 45 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | Florida | |
| 13. FATHER'S NAME | | | 14. MOTHER'S MAIDEN NAME | | |
| Charles Colbert | | | Annie | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| yes W W 2 | | | | Mr George Colbert 2724 E Oliver St | |
| 18. CAUSE OF DEATH | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | | |
| (A) Cirrhosis of liver DUE TO | | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | | | | |
| (B) DUE TO | | | | | |
| (C) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | yes | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) | | M.D. | | DATE SIGNED | |
| Rudiger Breitenacker, M.D. | | | | 9/27/65 | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) | | 23B. DATE | | 23C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 9/30/65 | | National Cemetry | |
| 24A. DATE REC'D BY HEALTH DEPT. | | 24B. NAME OF REGISTRAR | | 24C. FUNERAL DIRECTOR ADDRESS | |
| SEP 28 1965 | | Robert E. F... | | Adolphus Halstead 1206 W North Ave | |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

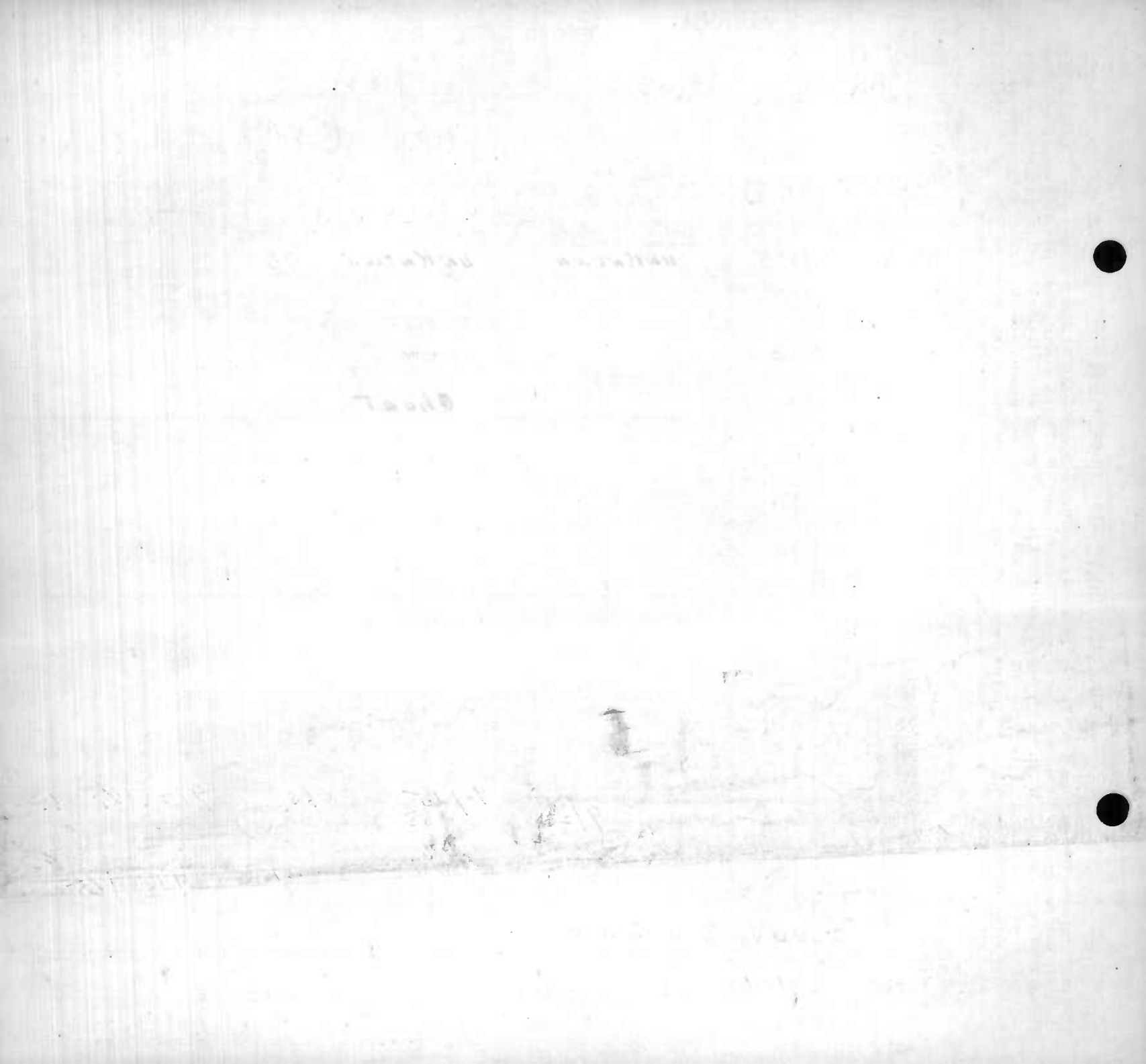
| Baltimore City Health Department | | | | Baltimore City Health Department | | Baltimore City Health Department | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|----------------------------------------------------------------------|--------------------------------|
| BIRTH NO. 15-2065 9944 | | | | M.E. CASE NO. | | Registered No. 65 9944 | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| William Bazille (BAZILE) | | | | September 25, 1965 9:15 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | | | A. STATE B. COUNTY | | | |
| Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | | Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2340 W. Fayette Street 21223 | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| Male | Negro | Widowed | 2-23-1891 | 74 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | |
| Laborer | | | Missouri | | U. S. A. | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Unknown | | | | Unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | |
| Yes WWI | | | | | RECORDS: BCH 4940 Eastern Avenue 21224 | | |
| 18. CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | (A) Carcinoma of Lung 6 Months | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (B) DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | (C) DUE TO | | | |
| Generalized Arteriosclerosis | | | | 2-4 Years | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 2 | | | | Yes | | Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from June 30, 1965 to September 25, 1965, that (I) (we) last saw the deceased alive on September 25, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | |
| Dr. John R. Burton M.D. | | | | 9-25-1965 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | |
| Dr. John R. Burton M.D. | | | | 4940 Eastern Avenue Balto., Md. 21224 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 9/30/65 | | National Cemetry | | Baltimore Md | |
| 25A. DATE REC'D BY HEALTH DEPT | | | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| SEP 28 1965 | | | | E. J. J. J. | | Adolphus Halstead 1206 W North Ave | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9945 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9945 | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) BROOKS, SAMUEL | | | |
| 2. DATE AND HOUR OF DEATH 9/23/65 5:20 AM | | | | M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hosp of Maryland | | | | A. STATE MD B. COUNTY U.S.A. | | | |
| 5. SEX Male 6. RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) UNKNOWN | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| 8. DATE OF BIRTH UNKNOWN 9. AGE (In years last birthday) 70 | | | | D. STREET ADDRESS (If rural, give location) ROSLYN AVE. - 634 | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 11. BIRTHPLACE (State or foreign country) | | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. Chart | | | |
| 17. INFORMANT ADDRESS | | | | | | | |
| 18. 331 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | |
| ANTECEDENT CAUSES | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (A) Cardiac arrest | | | |
| | | | | (B) C.V.A. uremia | | | |
| | | | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| | | While At Work <input type="checkbox"/> At Home <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/15 to 9/23/65 that (I) (we) last saw the deceased alive on 9/23 and that in (my) (our) opinion death occurred on the date and hour set forth from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Cherng Soc Shin | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/23/65 | |
| 23C. PHYSICIAN'S NAME (Type) CHERNG SOC SHIN | | | | 23D. ADDRESS | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/27/65 | | 24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery | | 24D. LOCATION (City, town, or county) (State) A A County Md | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | 25B. NAME OF REGISTRAR Robert E. Falkner | | 25C. FUNERAL DIRECTOR A. Holstead | | ADDRESS 1206 W. North Ave. | |

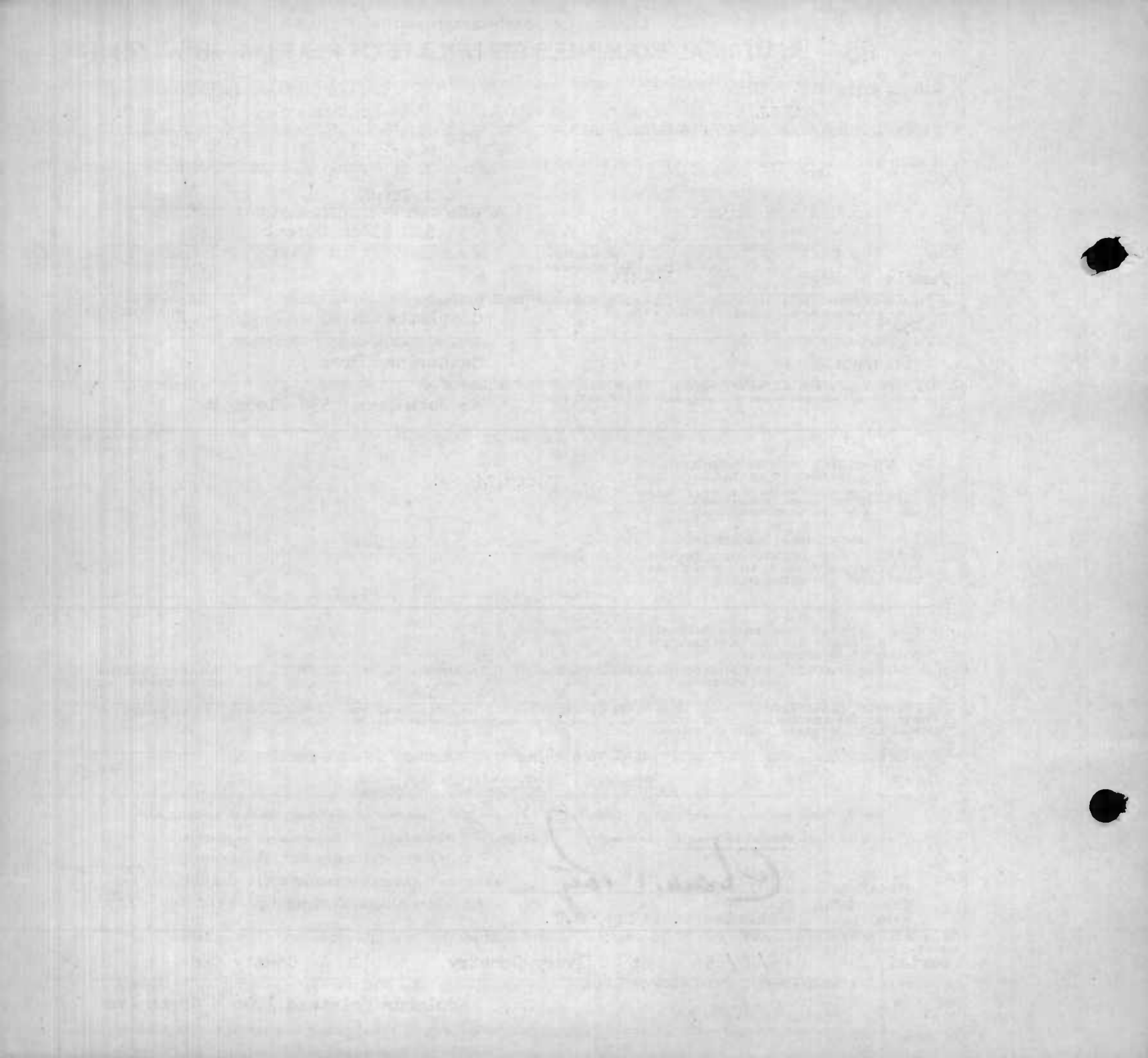


BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 9946 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 9946

M.E. CASE NO.

| | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print) | | WILLIE MAE HARRIS | | 2. DATE AND HOUR PRONOUNCED DEAD September 22, 1965 9:00 P. M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION 530 Bloom Street | | | A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 530 Bloom Street | | |
| 5. SEX Female | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH | 9. AGE (In years last birthday) 26 | 10. Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Charlotte N C | 12. CITIZEN OF WHAT COUNTRY? U S A |
| 13. FATHER'S NAME Unknown | | | 14. MOTHER'S MAIDEN NAME Catherine Drew | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS Mr John Drew 530 Bloom St | | |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Fatty Liver. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that I held on Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) | | Charles S. Petty, M.D. | | CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23B. DATE 9/27/65 | 23C. NAME OF CEMETERY or CREMATORY Mt Calvary Cemetry | | 23D. LOCATION (City, town, or county) (State) A A County Md |
| 24A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | 24B. NAME OF REGISTRAR Robert E. Taylor | | 24C. FUNERAL DIRECTOR ADDRESS Adolphus Halstead 1206 W North Ave | |



BALTIMORE CITY HEALTH DEPARTMENT

65 9947

BIRTH NO. 65 9947 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

M.E. CASE NO. _____

1. NAME OF DECEASED (Type or Print) **BESSIE B. STEWART** 2. DATE AND HOUR PRONOUNCED DEAD **September 24, 1965 12:01 P M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD **Provident Hospital** 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) **Maryland**

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) **Provident Hospital** 5. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**

6. STREET ADDRESS (If rural, give location) **2239 Druid Hill Avenue**

5. SEX **Female** 6. RACE **Negro** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) **Single** 8. DATE OF BIRTH **Jan. 15, 1893** 9. AGE (In years last birthday) **72** If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Domestic** 10B. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (State or foreign country) **Maryland** 12. CITIZEN OF WHAT COUNTRY? _____

13. FATHER'S NAME **Unknown** 14. MOTHER'S MAIDEN NAME **Unknown**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) _____ 16. SOCIAL SECURITY NO. **220-18-4572** 17. INFORMANT **Mr. Irvin Smith Stewart** ADDRESS **4406 Datona Street**

18. **163 X** CAUSE OF DEATH **Carcinoma of Lung.** INTERVAL BETWEEN ONSET AND DEATH _____

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION **0** 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 20A. AUTOPSY? (Yes or No) **No** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. ☐ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____ 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR? _____

22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Charles S. Petty** M.D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED **9/24/65**

EXAMINER'S NAME (Type) **Charles S. Petty, M.D.** ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

23A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 23B. DATE **9/30/65** 23C. NAME of CEMETERY or CREMATORY **Mt Mt Auburn Cemetery** 23D. LOCATION (City, town, or county) (State) **Baltimore Md**

24A. DATE REC'D BY HEALTH DEPT. **SEP 28 1965** 24B. NAME OF REGISTRAR **Robert E. Fisher** 24C. FUNERAL DIRECTOR **Adolphus Halstead** ADDRESS **1206 W North Ave**

VALLEY POLICE

REPORT

NO. 1

CHAS. J. [Signature]

FUNERAL DIRECTOR: IMPORTANT

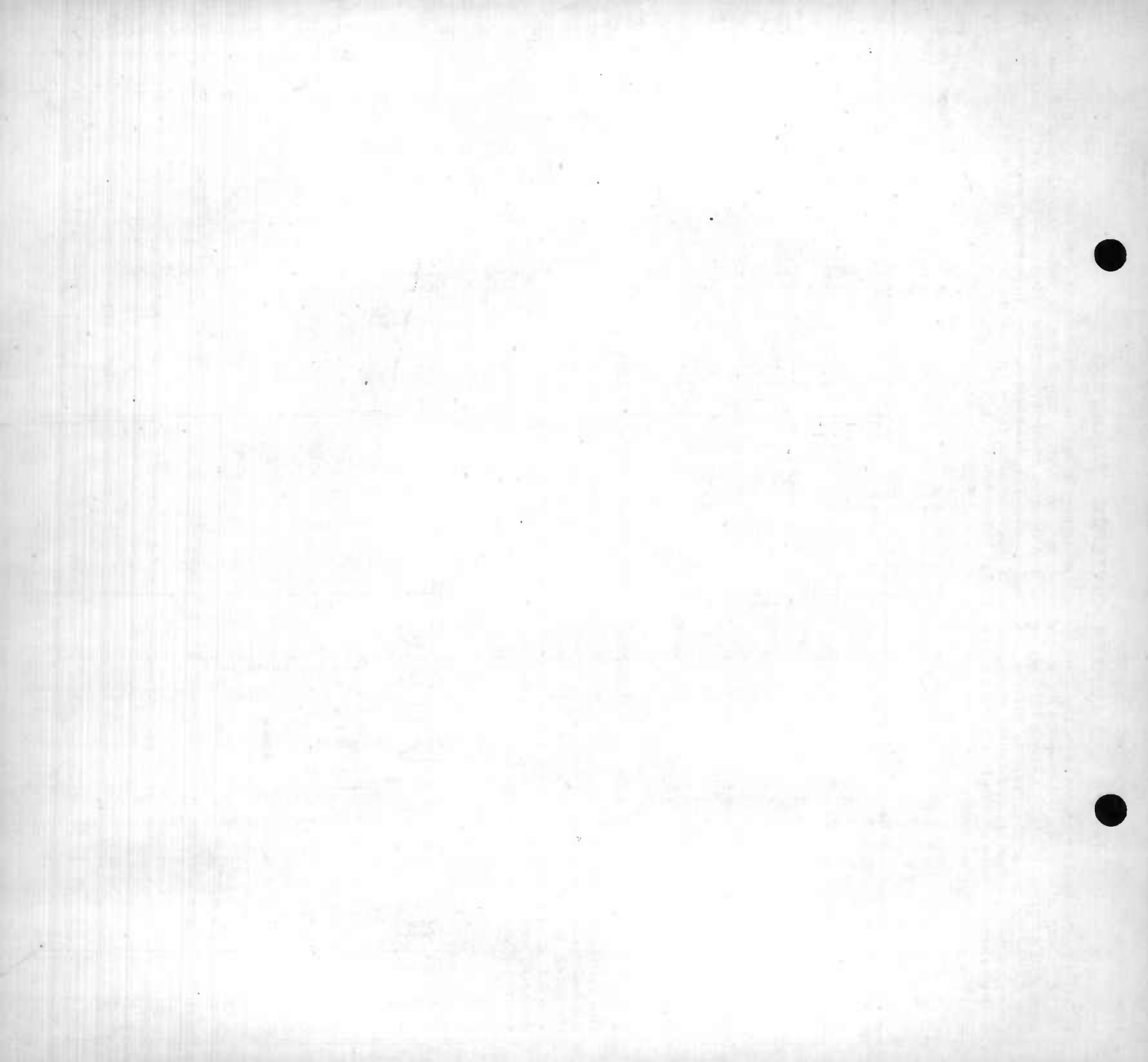
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. <u>65-2350365</u> <u>9948</u> | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. <u>65</u> <u>9948</u> <u>4</u> | |
| M.E. CASE NO. | | | CERTIFICATE OF DEATH | | |
| 1. NAME OF DECEASED (Type or Print) <u>BABY BOY ROGERS</u> | | | 2. DATE AND HOUR OF DEATH <u>9/15/65</u> <u>1:45 P.M.</u> | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>46 LUTHERAN HOSPITAL OF MARYLAND</u> | | | A. STATE <u>MD</u> B. COUNTY <u>15-09</u> | | |
| | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>4603 Forest Park Avenue</u> | | |
| | | | D. STREET ADDRESS (If rural, give location) <u>Baltimore, Maryland</u> | | |
| 5. SEX <u>M</u> | 6. RACE <u>C</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH <u>9/15/65</u> | 9. AGE (In years last birthday) | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13. FATHER'S NAME <u>Sylvester Fletcher</u> | | | 14. MOTHER'S MAIDEN NAME <u>DELORES ROGERS</u> | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT <u>MOTHER</u> | | ADDRESS <u>4603 Forest Park Avenue</u> |
| 18. <u>776 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>PREMATURITY</u> | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>9/15/65</u> <u>5:30AM</u> to <u>9/15/65</u> <u>11:45AM</u> , that (I) (we) last saw the deceased alive on <u>9/15</u> <u>19</u> <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>J. Perona</u> | | | 23B. DATE SIGNED <u>9/15/65</u> | | |
| 23C. PHYSICIAN'S NAME (Type) | | | 23D. ADDRESS <u>LUTHERAN HOSPITAL OF MARYLAND</u> | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE <u>SEP 28 1965</u> | | 24C. NAME OF CEMETERY OR CREMATORY <u>JOHNS HOPKINS MEDICAL SCHOOL</u> | |
| 24D. LOCATION (City, town, or county) | | 24E. ADDRESS | | 24F. ADDRESS | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 28 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Fisher</u> | | 25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCD</u> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9949 | |
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| BIRTH NO. 65-25642 65 9949 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | | 1. NAME OF DECEASED (Type or Print) Baby Boy SAUNDERS | | |
| 2. DATE AND HOUR OF DEATH 9/21/65 6:45 P. M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL OF MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE BALTIMORE B. COUNTY 15-48 | | |
| 5. SEX M 6. RACE C 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | | 8. DATE OF BIRTH 9/21/65 9. AGE (in years last birthday) 6 hours | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | |
| 10B. KIND OF BUSINESS OR INDUSTRY | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Percy Saunders Jr. | | | 14. MOTHER'S MAIDEN NAME Virginia Smith | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT FATHER | | | ADDRESS 3407 Eigin Avenue | | |
| 18. 773.5 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) PREMATURITY ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Respiratory Distress Syndrome | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/21/65 19 to 9/21/65 19, that (I) (we) lost saw the deceased alive on 9/21/65 6:45 PM 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Iskenna | | | | 23B. DATE SIGNED 9/21/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE SEP 28 1965 | | 24C. NAME OF CEMETERY or CREMATORY JOHNS HOPKINS MEDICAL SCHOOL | |
| 24D. LOCATION (City, town, or county) | | 24E. STATE | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | 25B. NAME OF REGISTRAR Robert E. Farber, M.D. | | 25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD | |
| 25D. ADDRESS | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9950 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9950 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Mrs. ANNA L. McCormack | | 2. DATE AND HOUR OF DEATH 9.27.65 12 ⁵⁰ A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | 5. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE Maryland | | B. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | |
| C. CITY OR TOWN | | D. STREET ADDRESS (If rural, give location) 6004 Yarroweth Rd. | | 53-00 | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed | 8. DATE OF BIRTH 6.12.99 | 9. AGE (In years last birthday) 66 | 10. If Under 1 Yr. Months Days |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10B. KIND OF BUSINESS OR INDUSTRY ? at home | | 11. BIRTHPLACE (State or foreign country) New York | |
| 13. FATHER'S NAME FRANK | | 14. MOTHER'S MAIDEN NAME Catherine Maxwell | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 0098-24-3782 | | 17. INFORMANT Hospital Chart | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO Acute Myocardial infarction rupture (B) DUE TO Coronary thrombosis (C) Pulmonary edema. | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9.24 1965 to 9.27 1965, that (I) (we) last saw the deceased alive on 9.27 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE [Signature] | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9.27.65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS M.D. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Removal | | 24B. DATE 9/27/65 | | 24C. NAME of CEMETERY or CREMATORY Mt. Carmel | |
| 24D. LOCATION (City, town, or county) (State) Tenefly New Jersey | | 25A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Fisher | | 25C. FUNERAL DIRECTOR William J. Fisher & Sons North Penna Ave | | | |

1008-SF-31
Hospital Chart
Catherine Maxwell
New York
6-13-39
6-13-39
General Hospital
F W
F W
F W

204

Dr. [Signature]

6-13-39

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

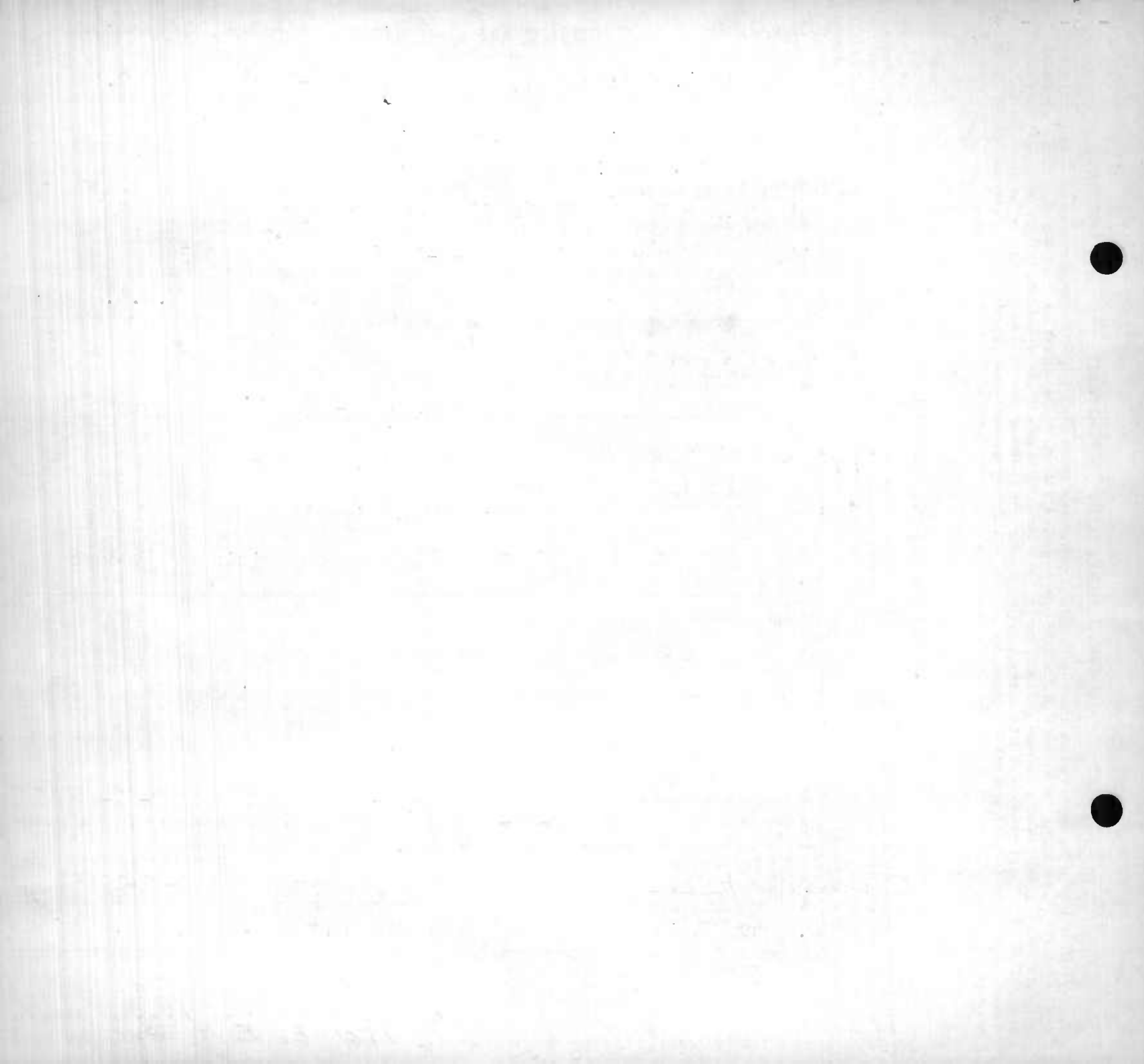
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| BIRTH NO. 65 9951 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9951 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) MARTIN J. WHITE, Jr. | | 2. DATE AND HOUR OF DEATH SEPTEMBER 25, 1965 9:12 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US PUBLIC HEALTH SERVICE HOSPITAL WYMAN PK DRIVE & 31 ST STREET | | 4. USUAL RESIDENCE (Where deceased lived last before residence before admission) A. STATE Maryland B. COUNTY AA CO ANNE ARUNDEL C. CITY OR TOWN (If outside city limits, write RURAL and give township) BETHESDA ELLICOTT CITY 52-00 D. STREET ADDRESS 379 Fleagle Road | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH JAN 15 1910 | 9. AGE (In years last birthday) 54 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HAULING CONTRACTOR | | 10B. KIND OF BUSINESS OR INDUSTRY CONTRACTING | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME MARTIN J. WHITE | | 14. MOTHER'S MAIDEN NAME KATHLEEN CONNELLY | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES USMC 1943 | | 16. SOCIAL SECURITY NO. 213-10 4133 | | 17. INFORMANT ADDRESS RECORDS USPHS Hospital Baltimore | |
| 18. 145.71 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonia | | (A) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH days | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO Metastatic carcinoma | | months | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | (C) DUE TO | | years | |
| 19A. DATE OF OPERATION 01 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NONE | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) N/A | |
| 21D. TIME OF INJURY (APPROX.) N/A | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> N/A Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? N/A | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/8 1964 to 9/25 1965, that (I) last saw the deceased alive on 9/25 1965 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE SAY M. Whitworth | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/25/65 | |
| 23C. PHYSICIAN'S NAME (Type) SAY M. WHITWORTH | | 23D. ADDRESS M.D. USPHS HOSPITAL, BALTIMORE, MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE SEP 29 65 | | 24C. NAME OF CEMETERY or CREMATORY LOUNDON PARK | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Jenkins | | 25C. FUNERAL DIRECTOR ADDRESS HARRY H. WITKE ELLICOTT CITY MD. | | | |

Corrected by letter from U. S. Marine Hosp. C. Bowens 10-28-65

CERTIFIED TRUE & CORRECT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65-13073 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9952 | |
| M.E. CASE NO. 65-13073 | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) Craig A. Nelson | | | 2. DATE AND HOUR OF DEATH 9-21-1965 2.10 P.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 26-36 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1306 Ballard Way 21224 | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED NEVER MARRIED | 8. DATE OF BIRTH 6-4-1965 | 9. AGE (In years last birthday) 3 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Kenneth Nelson, Sr. | | | |
| 14. MOTHER'S MAIDEN NAME Mary Adams | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Hyperkalemia, Acidosis | | | INTERVAL BETWEEN ONSET AND DEATH 12 hours | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) Dehydration, Oliguria DUE TO 1 day | | |
| (C) Diarrhea 2° Gastroenteritis DUE TO 3 days | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-21-1965 to 9-21-1965 , that (I) (we) last saw the deceased alive on 9-21-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE S. Wayne Klein | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-21-1965 |
| 23C. PHYSICIAN'S NAME (Type) S. Wayne Klein | | | 23D. ADDRESS M.D. 4940 Eastern Avenue, Baltimore, Maryland | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/24/65 | | 24C. NAME of CEMETERY or CREMATORY Green Haven Cemetery | |
| 24D. LOCATION Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR Charles W. Stevens Funeral Home, Inc. | | | |
| 25D. ADDRESS 1501 E. Fort Ave. | | | | | |



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| BIRTH NO. 65 9953 | | BALTIMORE CITY HEALTH DEPARTMENT | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 9953 | |
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| M.E. CASE NO. | | | 2. DATE AND HOUR PRONOUNCED DEAD September 24, 1965 8:35 P.M. | | |
| 1. NAME OF DECEASED (Type or Print) DEBORAH LEAR | | | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) St. Agnes Hospital | | |
| 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 2401 | | |
| D. STREET ADDRESS (If rural, give location) 1415 Reynolds St. | | | | | |
| 5. SEX female | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Never Married | 8. DATE OF BIRTH 10/2/51 | 9. AGE (In years last birthday) 13 | If Under 1 Yr. (f Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTH PLACE (State or foreign country) Baltimore | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME John J. Lear | | | 14. MOTHER'S MAIDEN NAME Betty Brown | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | |
| 17. INFORMANT John J. Lear 1415 Reynolds St. | | | ADDRESS | | |
| 18. CAUSE OF DEATH E8234 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Asphyxia Crushing injury of larynx ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) River Rd. 3/4 mi. E. of Ranger Station | |
| 21D. TIME OF INJURY (APPROX.) 9-24-65 7:40 P.M. | | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? Auto ran into ditch | |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breiteneker, M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | 23B. DATE 9/28/65 | | |
| 23C. NAME OF CEMETERY or CREMATORY Holy Cross Cemetery | | | 23D. LOCATION (City, town, or county) (State) Anne Arundel, Md. | | |
| 24A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | | 24B. NAME OF REGISTRAR Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue | | |

WALLEY FORCE

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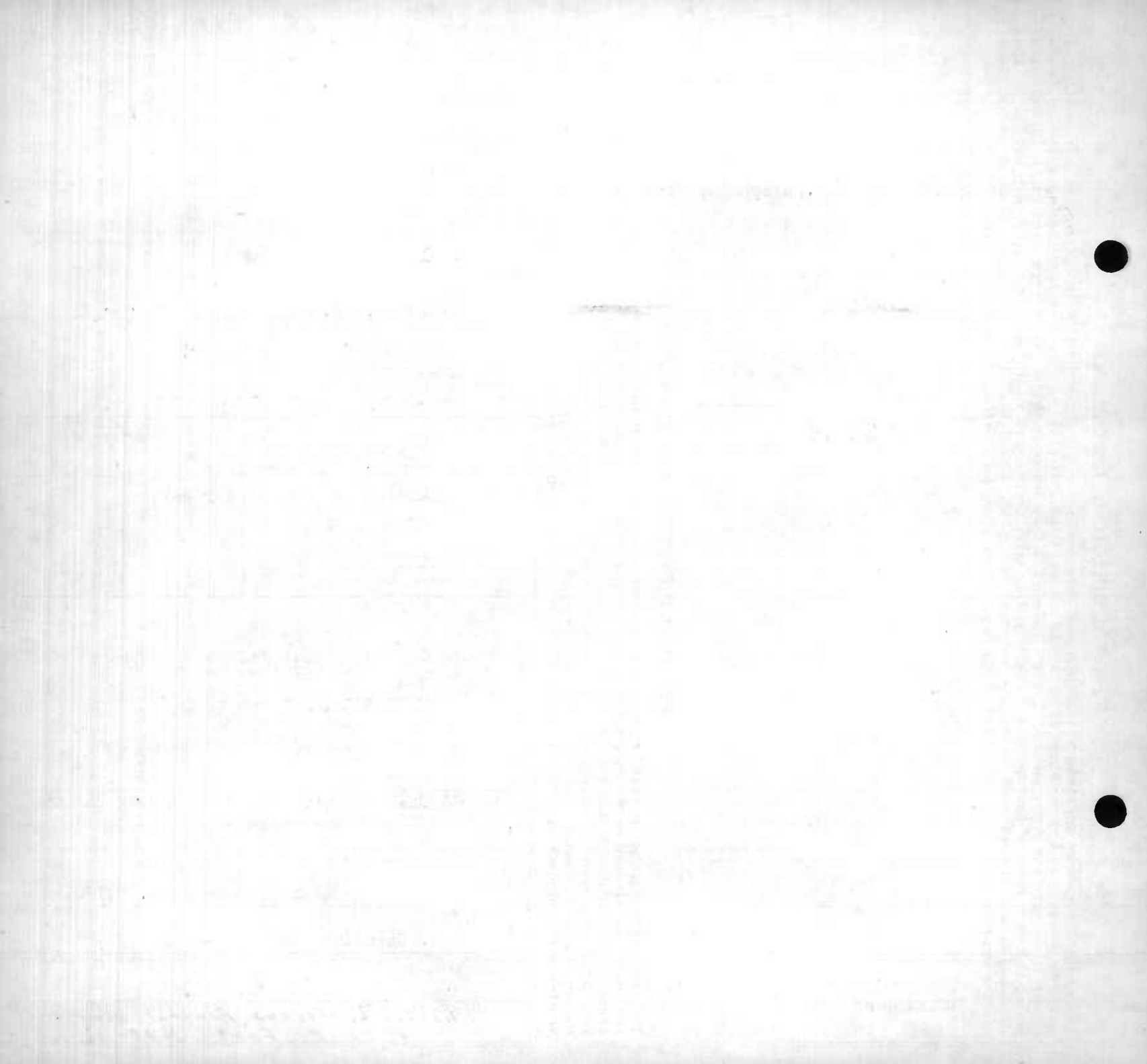
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

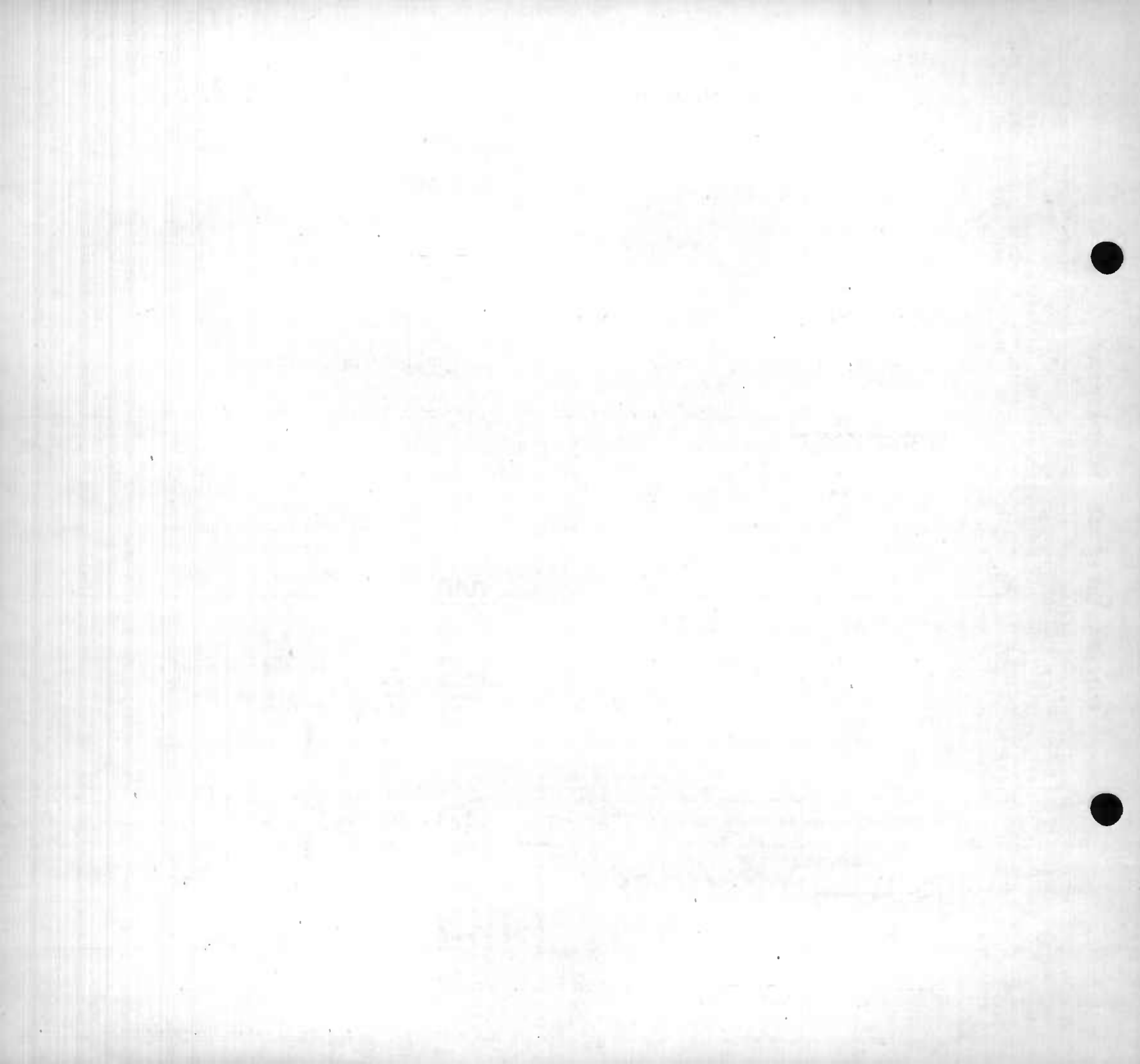
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9954 | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|------------------------------------------|
| BIRTH NO. 65 9954 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) VOGEL, ANN VIOLA | | | 2. DATE AND HOUR OF DEATH Sept. 24, 1965 3:18 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph Hospital | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1133 Hull Street - 21230 | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 2-2-15 | 9. AGE (In years lost birthday) 50 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook | | 10B. KIND OF BUSINESS OR INDUSTRY ----- | | 11. BIRTHPLACE (State or foreign country) Baltimore, Md. | |
| 13. FATHER'S NAME John | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. 216-18-7582 | | |
| 17. INFORMANT Edward J. Vogel | | | ADDRESS 1133 Hull St. | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hepatic carcinoma with cirrhosis with 2° bleeding esophageal varices. | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | (B) DUE TO (C) ----- | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) None | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from August 30, 19 65 to September 24, 19 65 , that (I) (we) lost saw the deceased alive on September 24, 19 65 and that in (my) xxx opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (xxxx) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Fiorello G. Malit</i> M.D. | | | | 23B. DATE SIGNED Sept. 24, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Fiorello G. Malit | | | | 23D. ADDRESS 1400 N. Caroline Street - 21213 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/27/65 | | 24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery | |
| 24D. LOCATION Baltimore, Md. | | 24E. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | | |
| 25A. NAME OF REGISTRAR Robert E. Finken | | 25B. NAME OF REGISTRAR Charles L. Stevens | | | |
| 25C. FUNERAL DIRECTOR Charles L. Stevens | | 25D. ADDRESS 1501 E. Fort Avenue | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

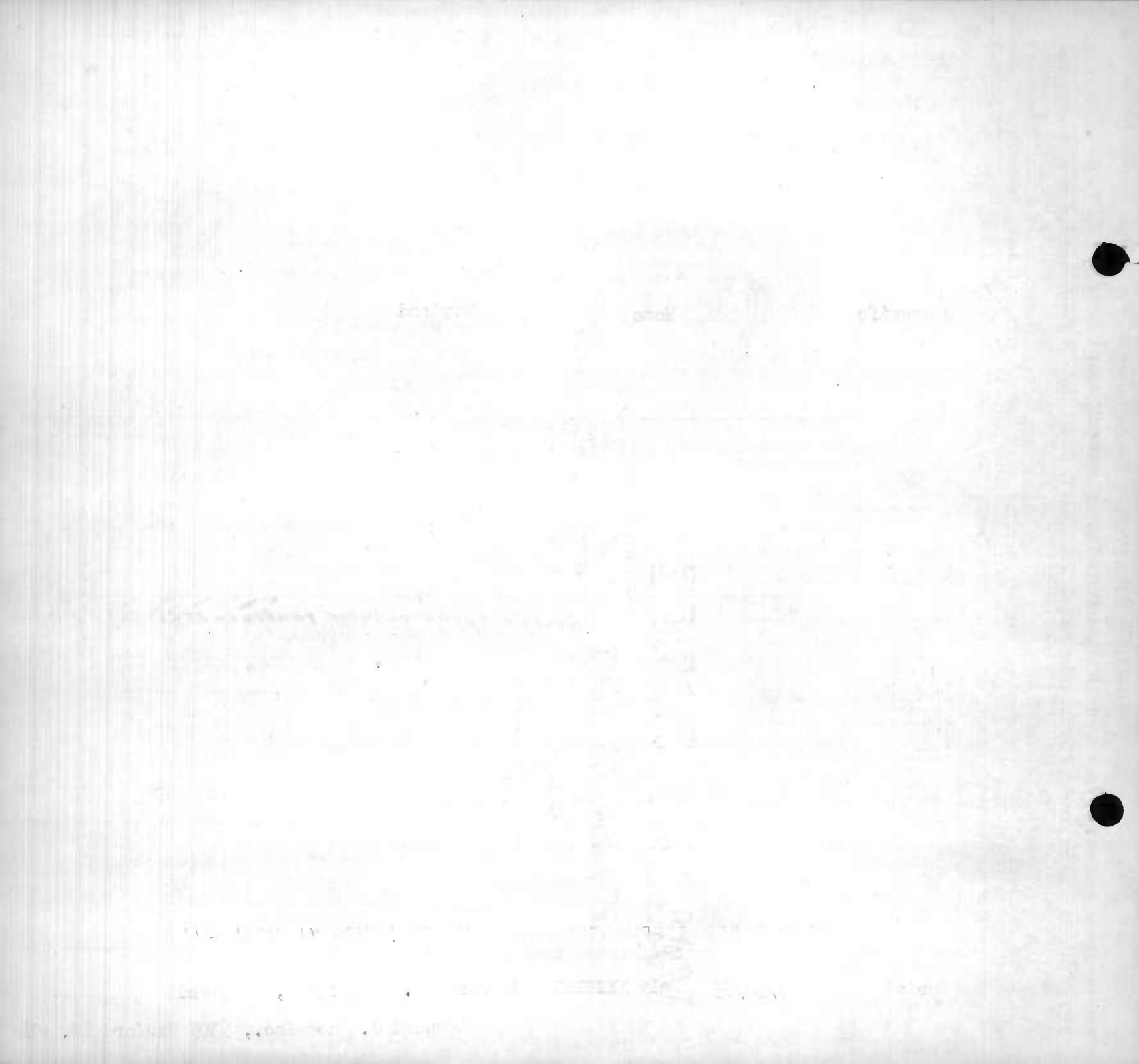
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9955 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) 65 9955 John H. Hardy | | 2. DATE AND HOUR OF DEATH September 27, 1965 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2808 Rosalie Ave. | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Md. B. COUNTY 2707 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2808 Rosalie Ave. | | | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) widowed | 8. DATE OF BIRTH 7-25-1899 | 9. AGE (In years lost birthday) 66 | If Under 1 Yr. Months: If Under 24 Hrs. Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Clerk | | 10B. KIND OF BUSINESS OR INDUSTRY B & O R.R. | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME John W. Hardy | | | |
| 14. MOTHER'S MAIDEN NAME Catherine Schulte | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 705053710 | | | |
| 17. INFORMANT Mrs Doris Schmidt | | ADDRESS same | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Ruptured abdominal aortic aneurysm DUE TO (B) Cerebral aneurysm C.V.D. DUE TO (C) | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1965 to Sept. 27 1965, that (I) (we) last saw the deceased alive on 9-24 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE J. Henry Haresse M.D. | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED SEP 28 1965 | |
| 23C. PHYSICIAN'S NAME (Type) J. Henry Haresse M.D. | | 23D. ADDRESS 2926 E. C. & N. Spring Lane | | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) burial | | 24B. DATE 9-30-65 | | 24C. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc Baltimore, Md. | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT Certificate of Death | | | | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-----------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|----------------------------------------------------------------------|------------------------------------------------|-------------------------------------|--|
| BIRTH NO. 65 9956 | | Registered No. 65 9956 | | | | | | | |
| M.E. CASE NO. | | | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | | | Mary Margaret Mooney | | | 2. DATE AND HOUR OF DEATH 9/27/65 3:30 A.M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital | | (If not in hospital or institution, give street address or location) | | A. STATE Maryland | | B. COUNTY 12-06 | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | | | |
| | | | | D. STREET ADDRESS 2327 N. Charles St. Melcher Nursing Home | | | | | |
| 5. SEX F | 6. RACE Cauc | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | | 8. DATE OF BIRTH 2-2-93 | 9. AGE (In years last birthday) 72 | 10. Under 1 Yr. Months Days | | 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife NUNE | | | | 10B. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Joseph Smeykal | | | | 14. MOTHER'S MAIDEN NAME Mary Faleinstein | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Elizabeth Amrein Carnety 21234 | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonia | | | | CAUSE OF DEATH Pneumonia | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | Rupt. Gonorrheal Appendix and bowel | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | Congestive heart failure - acute Recent SUPRACONDYLAR FRACTURE RT DISTAL FEMUR HASCVD - New Cerebral Vascular accident - Pneumonia | | | | | |
| 19A. DATE OF OPERATION 9/24/65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Pneumonia - Bowel Obst. | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/24/65 19 to 9/27/65 19, that (I) (we) last saw the deceased alive on 9/27/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Richard Rider Stephenson | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/27/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) RICHARD RIDER STEPHENSON, M.D. | | | | 23D. ADDRESS UNION MEMORIAL HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/30/65 | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem. | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | 25B. NAME OF REGISTRAR R. E. Faleinstein | | 25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. | | 25D. ADDRESS 5305 Harford Rd. #714 | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9957 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9957 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>Albert C. Hundertmark</i> | | 2. DATE AND HOUR OF DEATH <i>9/27/65</i> <i>4:20 P</i> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Charch Home & Hospital</i> | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Balto</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> <i>53-00</i> D. STREET ADDRESS (If rural, give location) <i>57 Northship Road</i> | | | |
| 5. SEX MALE | 6. RACE CAUCASIAN | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH <i>6-27-11</i> | 9. AGE (In years last birthday) <i>54</i> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Employee Driver Salesman</i> | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <i>Maryland</i> | |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME <i>Frederick L. Hundertmark</i> | | 14. MOTHER'S MAIDEN NAME <i>Anna M. McGrieder</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>213-12-3772</i> | | 17. INFORMANT <i>MRS. WANDA HUNDERMARK</i> | |
| 18. <i>260X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Diabetes mellitus, 10 years</i> <i>HTN, arterial, Burn</i> | | (A) <i>Uremia, chronic</i> DUE TO (B) <i>Diabetic Coma with retention of ure</i> DUE TO (C) <i>Diabetic Mellitus</i> DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <i>months</i> <i>1 year</i> | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>9-14-65</i> 19 <i>65</i> to <i>9-27</i> 19 <i>65</i> , that (I) (we) lost saw the deceased alive on <i>9-27-65</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Jose S. Maisog</i> | | 23B. DATE SIGNED <i>9-27-65</i> | | 23C. PHYSICIAN'S NAME (Type) <i>Jose S. Maisog</i> | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE <i>9/30/65</i> | | 24C. NAME of CEMETERY or CREMATORY <i>GARDENS OF FAITH CEMETERY</i> | |
| 24D. LOCATION (City, town, or county) (State) <i>BALTO., MD.</i> | | 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 28 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Talbot</i> | |
| 25C. FUNERAL DIRECTOR <i>Leonard J. Fackler</i> | | 25D. ADDRESS <i>5305 Halfway Rd</i> | | 25E. ADDRESS | |

Charles Thomas & Houghton

Frederick of Houghton
George of Houghton

to be kept for
1877-78

Harvard
Anna B. B. B.

~~John B. B. B.~~
John B. B. B.
John B. B. B.
John B. B. B.

John B. B. B.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9958 | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|-----------------------------------------------------------------------------|-------------------------------------------|
| BIRTH NO. 65 9958 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | CHRISTIAN SCHMEISER of | | 9/23/65 11:45 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 305 Gittings Avenue-12 | | A. STATE Maryland | | | |
| | | B. COUNTY Baltimore | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) 305 Gittings Avenue-12 | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH Jan. 5, 1879 | 9. AGE (In years last birthday) 86 | 10. Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant-retail | | 10B. KIND OF BUSINESS OR INDUSTRY Meats | | 11. BIRTHPLACE (State or foreign country) Baltimore | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME George Schmeiser | | | |
| 14. MOTHER'S MAIDEN NAME Louise Foltz | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no - | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Minnie LeBrun Schmeiser | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 151 X I | | CAUSE OF DEATH (A) Cardiac Decompensation DUE TO (B) Carcinoma Stomach DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH 4 weeks. 1 year | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) no | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 1 July 1950 to 23 Sept 1965 , that (I) (we) last saw the deceased alive on 23 Sept 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Charles H. Reier | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 25 Sept 65 | |
| 23C. PHYSICIAN'S NAME (Type) Charles H. Reier | | 23D. ADDRESS M.D. 6701 York Rd-12 | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) Burial | 24B. DATE 9/27/65 | 24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cem. | | 24D. LOCATION (City, town, or county) (State) Balto. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | 25B. NAME OF REGISTRAR Robert E. Falkland | | 25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc | |
| | | | | ADDRESS 6500 York Road-12 | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. 65-24431 65 9959 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9959 | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) DIETZ, BABY BOY | | | 2. DATE AND HOUR OF DEATH 9-25-65 9AM M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL BALTIMORE, MARYLAND 21229 | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) GLEN BURNIE D. STREET ADDRESS (If rural, give location) 1013 SHARON DRIVE | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE | 8. DATE OF BIRTH 9-23-65 | 9. AGE (In years last birthday) 2 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BABY | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | 13. FATHER'S NAME STUART C. DIETZ | | |
| 14. MOTHER'S MAIDEN NAME NOLA O'DELL | | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | |
| 16. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS BALTO. 29, MD | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | CAUSE OF DEATH (A) Respiratory Distress Syndrome DUE TO (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH 48 hours | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (X) (this hospital) attended the deceased from 9-23-19 65 to 9-25-19 65, that (X) (we) last saw the deceased alive on 9-25-19 65 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXX) view the body after death. | | | | | |
| 23A. SIGNATURE Humberto G. Hernandez | | | | 23B. DATE SIGNED 25 September 1965 | |
| 23C. PHYSICIAN'S NAME (Type) HUMBERTO G. HERNANDEZ | | | | 23D. ADDRESS St Agnes Hospital Baltimore MD. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/27/65 | | 24C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial | |
| 24D. LOCATION (City, town, or county) Glen Burnie, Md. | | 25A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | | |
| 25B. NAME OF REGISTRAR Robert E. Taylor | | 25C. FUNERAL DIRECTOR NIRLEY FURMAN/Horne | | | |
| 25D. ADDRESS Glen Burnie Md. | | | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9960 | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|-----------------------------------------------------------------------|------------------------------------------------------------|
| BIRTH NO. | | M.E. CASE NO. | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Strube, John Louis | | 9/24/65 | | 9:00 P. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| Montebello State Hospital | | Maryland Baltimore | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Lansdowne 5300 | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 28 4th Avenue | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| Male | White | Married | 4/26/1891 | 74 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Engineer for Stieff Silver Co. | | | | Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| John Strube | | Margaret Meeb | | USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| No | | 215-01-7117 | | Hospital Records 21227 Mrs. Marie Strube-28 Fourth Ave-Lansdowne, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | (A) Sarcoma of Rt. Scapula with Metastasis | | 2 yrs. | |
| ANTECEDENT CAUSES | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Polycystic Kidneys | | Unknown | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 2 | | Yes | No | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | | | |
| | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 12/9/64 to 9/24/65, that (I) (we) last saw the deceased alive on 9/24/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED | |
| Daniel G. Lai | | | | 9/24/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Daniel G. Lai | | 2201 Argonne Drive, Baltimore, Md. 21218 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME of CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) | | |
| Burial | 9-28-65 | Loudon Park Cemetery | Baltimore, Maryland | | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR ADDRESS | | | |
| SEP 28 1965 | | Howard H. Hubbard-4107 Wilkens Avenue-21229 | | | |

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | | | | | | |
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| BIRTH NO. 65 9961 | | <div>CERTIFICATE OF DEATH</div> <div>Registered No. 65 9961</div> | | | | | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) WATSON, GARLAND, MITCHELL | | | | 2. DATE AND HOUR OF DEATH 9-26-65 7:10A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21227 D. STREET ADDRESS (If rural, give location) 2914 CHARLESTON AVE. | | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 6-15-00 | 9. AGE (In years last birthday) 65 | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME EDGAR | | | | | 14. MOTHER'S MAIDEN NAME CORNELIA FISHER | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 218-05-4173 | | 17. INFORMANT ADDRESS WILKENS AVE. 21229 ST. AGNES HOSPITAL RECORDS-CATON & | | | | |
| 18. 152.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Severe malnutrition DUE TO Adenocarcinoma of the DUE TO Small intestine & neoblastosis | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) YES | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS CONTRIBUTING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-20- 19 65 to 9-26- 19 65 , that (I) (we) last saw the deceased alive on 9-26 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Strahil Kacer M.D. | | | | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | | |
| 23C. PHYSICIAN'S NAME (Type) STRAHIL Kacer M.D. | | | | | 23D. ADDRESS | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/29/65 | | 24C. NAME of CEMETERY or CREMATORY Meadowridge Memorial Park | | 24D. LOCATION (City, town, or county) (State) Elkridge, Maryland | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley M.D. | | 25C. FUNERAL DIRECTOR ADDRESS Hubbard Funeral Home 4107 Wilkens Ave. 21229 | | | | | |

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ST. AGNES HOSPITAL

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MALE WHITE MARRIED

U.S.A. VIRGINIA TROOPMASTER

CORRECTIONAL INSTITUTION EDGAR

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BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JAMES MILLER, JR.

2. DATE AND HOUR PRONOUNCED DEAD

September 8, 1965 | 6:10 A.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

Unknown

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

never married

8. DATE OF BIRTH

10-1-23

9. AGE (In years
last birthday)

41

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Unknown

10B. KIND OF BUSINESS OR INDUSTRY

Unknown

11. BIRTHPLACE (State or foreign country)

Louisiana

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

James E. Miller Sr.

14. MOTHER'S MAIDEN NAME

Ethel

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes WWII

16. SOCIAL
SECURITY NO.

?

17. INFORMANT

Mrs. Edward A. Norman

ADDRESS

71 Pepper Point Baltimore

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Fatty metamorphosis of the liver
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/8/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

9-29-65

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

(State)

Baltimore

24A. DATE REC'D BY HEALTH DEPT.

SEP 29 1965

24B. NAME OF REGISTRAR

Robert E. Jackson

24C. FUNERAL DIRECTOR

Robert E. Jackson, Seaside Park, Md.

ADDRESS

WALLACE JOHNSON

NOV 10 1911

[Faint signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9963 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9963 | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|-----------------------------------------------------------------------------|--|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) JOHN MICHAEL RIPKEN | | | | 2. DATE AND HOUR OF DEATH SEPTEMBER 26, 1965 6:55 P M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 25-06 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 3710 FOURTH STREET | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 2-1-98 | 9. AGE (In years last birthday) 67 | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - Foreman | | | 10B. KIND OF BUSINESS OR INDUSTRY Oil Co. | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | 13. FATHER'S NAME WILLIAM Ripken | | | | |
| 14. MOTHER'S MAIDEN NAME Anna Silverson | | | 15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) YES | | | | |
| 16. SOCIAL SECURITY NO. 214018551 | | | 17. INFORMANT AVENUE ST. AGNES RECORDS WILKINS AND CATON | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 163X I Carcinoma of the lungs with metastasis to the brain | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (X) (this hospital) attended the deceased from SEPTEMBER 10 1965 to SEPTEMBER 26 1965 , that (X) (we) last saw the deceased alive on SEPTEMBER 26 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Hiram A. Ruiz M.D. | | | | 23B. DATE SIGNED 9/25/65 | | 23C. PHYSICIAN'S NAME (Type) HIRAM A. RUIZ M.D. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-29-1965 | | 24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem. | | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 29 1965 | | 25B. NAME OF REGISTRAR Robert E. Finkbeiner | | 25C. FUNERAL DIRECTOR George J. Gonce - 4001 Ritchie Hwy. | | | |
| ADDRESS Baltimore 25, Md. | | | | | | | |

RECEIVED IN 1964

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9964 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9964 | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------|------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|------------------------------------------------------------------------------------|--|
| 1. NAME OF DECEASED (Type or Print) McKee, Edwin B. | | | | 2. DATE AND HOUR OF DEATH Sept. 26, 1965 | | 7:00 a. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph Hospital | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #28 D. STREET ADDRESS (If rural, give location) 206 Rollingfield Road | | | |
| 5. SEX Male | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 4-26-21 | 9. AGE (In years last birthday) 44 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel Sparrows Point | | 11. BIRTHPLACE (State or foreign country) Allentown, Pa. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME EDWIN B. MCKEE SR. | | | | 14. MOTHER'S MAIDEN NAME CRANDALL | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II | | 16. SOCIAL SECURITY NO. 215165964 | | 17. INFORMANT HOSP. REC. | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Severe emphysema with pulmonary insufficiency ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cor pulmonale | | | | CAUSE OF DEATH (A) Severe emphysema with pulmonary insufficiency (B) Cor pulmonale DUE TO (C) | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 5-27-61 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) Yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept. 19, 1965 to Sept. 26, 1965 , that (I) (we) last saw the deceased alive on Sept. 26, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Govinda Rao | | | | M.D. <input type="checkbox"/> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Sept. 26, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Govinda Rao | | | | 23D. ADDRESS M.D. 1400 N. Caroline St., 21213 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/29/65 | | 24C. NAME of CEMETERY or CREMATORY MORELAND | | 24D. LOCATION (City, town, or county) (State) BALTO. MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 29 1965 | | 25B. NAME OF REGISTRAR Robert E. Fabela | | 25C. FUNERAL DIRECTOR E. S. MACNABB | | ADDRESS 301 FREDERICK RD 21428 | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 1965 | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|---------------------------------------------------------------------------------------------|----------------------------------------------------------------|
| BIRTH NO. 65 9365 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <i>James P. Healy</i> | | 2. DATE AND HOUR OF DEATH <i>9-27-65 11:35 A.M.</i> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>md.</i> B. COUNTY <i>26-36</i> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> | |
| FULL NAME OF HOSPITAL OR INSTITUTION <i>Mercy Hospital</i> | | (If not in hospital or institution, give street address or location) | | D. STREET ADDRESS (If rural, give location) <i>1225 Toplin St.</i> | |
| 5. SEX <i>M</i> | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i> | 8. DATE OF BIRTH <i>3-15-87</i> | 9. AGE (In years last birthday) <i>78</i> | If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Police Guard</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Hospital</i> | | 11. BIRTHPLACE (State or foreign country) <i>Balto Md</i> | |
| 13. FATHER'S NAME <i>PATRICK HEALY</i> | | 14. MOTHER'S MAIDEN NAME <i>JOHANNA CAVNEY</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i> | | 16. SOCIAL SECURITY NO. <i>---</i> | | 17. INFORMANT <i>Mrs Mary A. Healy Belowe</i> | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Uremia</i> | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i> <i>one year</i> | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Arteriosclerotic cardiovascular disease</i> <i>Chronic bronchitis and emphysema</i> | | years | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) <i>no</i> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>August 4</i> 19 <i>65</i> to <i>September 27</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>September 27</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Nelson C. Sun</i> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>9/27/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) <i>NELSON C. SUN</i> | | M.D. | | 23D. ADDRESS <i>MERCY HOSPITAL</i> | |
| 24A. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i> | | 24B. DATE <i>9-30-65</i> | | 24C. NAME OF CEMETERY or CREMATORY <i>New Cathedral</i> | |
| 24D. LOCATION <i>Beth Md</i> | | 24E. DATE REC'D BY HEALTH DEPT. <i>SEP 29 1965</i> | | 24F. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i> | |
| 24G. DATE REC'D BY HEALTH DEPT. <i>SEP 29 1965</i> | | 24H. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i> | | 24I. FUNERAL DIRECTOR <i>John J. Cowan & Son Inc.</i> | |
| 24J. ADDRESS <i>Hollins St</i> | | 24K. ADDRESS <i>801</i> | | 24L. ADDRESS <i>801</i> | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department | | | | Registered No. 65 9966 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|-------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. 65 9966 | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | MYER, PETER, THOMAS (STANKIEWICZ) | | 9-26-65 12:55 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| ST. AGNES HOSPITAL | | MARYLAND | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | BALTIMORE 21226 | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 1608 CHURCH ST. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| MALE | WHITE | MARRIED | 3-24-03 | 62 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| RIGGER | | & DRYDOCK MD. SHIPBUILDING | | POLAND | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| THOMAS | | ANNA BYTELLA | | U.S.A. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| NO | | 213-10-8199 | | ST. AGNES HOSPITAL RECORDS CATON AVE. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | | INTERVAL BETWEEN ONSET AND DEATH |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (A) Acute Myocardial infarction DUE TO (B) Carcinoma of esophagus. DUE TO (C) Emphysema Left Vent Hy. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Anterolateral ischemic heart | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 39-24-1465 | | Ca of esophagus | | YES | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 8-20 19 65 to 9-26 19 65, that (I) (we) last saw the deceased alive on 9-26 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| Detario de Marchena | | | | 9-26-1965 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| Detario de Marchena | | St Agnes Hospital | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | |
| Burial | | 9-30-65 | | Cedar Hill Cem. | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. | | | |
| Anne Arundel Co., Md. | | SEP 29 1965 | | | |
| 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | 25D. ADDRESS | |
| R. E. E. Farley | | Wm. G. Fialkowski | | 2007 Eastern Ave. Balto. Md. 21231 | |

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1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618 2619 2620 2621 2622 2623 2624 2625 2626 2627 2628 2629 2630 2631 2632 2633 2634 2635 2636 2637 2638 2639 2640 2641 2642 2643 2644 2645 2646 2647 2648 2649 2650 2651 2652 2653 2654 2655 2656 2657 2658 2659 2660 2661 2662 2663 2664 2665 2666 2667 2668 2669 2670 2671 2672 2673 2674 2675 2676 2677 2678 2679 2680 2681 2682 2683 2684 2685 2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701 2702 2703 2704 2705 2706 2707 2708 2709 2710 2711 2712 2713 2714 2715 2716 2717 2718 2719 2720 2721 2722 2723 2724 2725 2726 2727 2728 2729 2730 2731 2732 2733 2734 2735 2736 2737 2738 2739 2740 2741 2742 2743 2744 2745 2746 2747 2748 2749 2750 2751 2752 2753 2754 2755 2756 2757 2758 2759 2760 2761 2762 2763 2764 2765 2766 2767 2768 2769 2770 2771 2772 2773 2774 2775 2776 2777 2778 2779 2780 2781 2782 2783 2784 2785 2786 2787 2788 2789 2790 2791 2792 2793 2794 2795 2796 2797 2798 2799 2800 2801 2802 2803 2804 2805 2806 2807 2808

1997-1998

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9967 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9967 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | 5 ⁰⁰ P. M. | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| Dominic J. Bunjon. | | Sept 26, 1965 | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| 1244 W. 37th St. | | Maryland | | 3-08 | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | Baltimore | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 1244 W. 37th St. | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| Male | White | Married | May 4, 1906 | 59 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| Laborer | | John Hampshire Co | | Maryland | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | | 12. CITIZEN OF WHAT COUNTRY? | |
| Joseph Bunjon. | | Bertha LaRosa | | U.S. | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | Pauline V. Bunjon. 1244 W. 37th St. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 420.1 I | | Coronary Occlusion | | | |
| ANTECEDENT CAUSES | | (A) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| | | (C) | | | |
| II | | Arteriosclerotic - Cardio-Vascular disease | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 0 | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? | | | |
| | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Feb 19 65 to Sept 19 65, that (I) last saw the deceased alive on Sept 5 19 65 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | 23B. DATE SIGNED | | | |
| William G. Helfrich | | 9-28-65 | | | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| WILLIAM G. HELFRICH | | 5006 Roland Ave. Balto 10, Md. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME of CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) | | |
| Burial | 9/30/65 | New Cathedral | Old Frederick Rd, Md. | | |
| 25A. DATE REC'D BY HEALTH DEPT. | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR ADDRESS | | | |
| SEP 29 1965 | Robert E. Fink | Donovan Funeral Home | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 65 9968 | | Registered No. | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|------------------------------------------------------------------------|--|
| BIRTH NO. 65 9968 | | CERTIFICATE OF DEATH | | DATE AND HOUR OF DEATH 9/26/65 12 15 A M. | | | |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) SARAH GOEBRICHER | | 2. DATE AND HOUR OF DEATH 9/26/65 12 15 A M. | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSP. of BALTO. INC. | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE OHIO B. COUNTY SINAI HOSP. SINCE 1932 C. CITY OR TOWN (If outside city limits, write RURAL and give township) V-32 D. STREET ADDRESS (If rural, give location) | | | | | |
| 5. SEX FEMALE | 6. RACE CAUCASIAN | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE | 8. DATE OF BIRTH 9/15/1868 | | 9. AGE (In years last birthday) 97 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) OHIO | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME UNKNOWN | | | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT HARRY WEINTRAUB | | ADDRESS 2300 W. 10th - OHIO | |
| 18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. PNEUMONIA, Pseudomonas | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) ARTERIO SCLEROTIC CARDIO- VASCULAR DISEASE (senescence) - 20 yrs. | | INTERVAL BETWEEN ONSET AND DEATH 1 mos. | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) NO | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) NO | | | |
| 21D. TIME OF INJURY (APPROX.) NO | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? NO | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/26 19 65 to 9/26 19 65, that (I) (we) last saw the deceased alive on 9/26 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Joseph A. Weintraub | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9/26/65 | |
| 23C. PHYSICIAN'S NAME (Type) SARAH GOEBRICHER | | | | 23D. ADDRESS SINAI HOSP. of BALTO. INC., MD | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/30/65 | | 24C. NAME OF CEMETERY or CREMATORY BALTO Hebrew Cemetery | | 24D. LOCATION (City, town, or county) (State) Belair Rd. BALTO. MD. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 29 1965 | | 25B. NAME OF REGISTRAR Robert E. Finkler | | 25C. FUNERAL DIRECTOR JACK LEWIS INC. | | ADDRESS 2100 2 EUTAW PL. BALTO. MD. | |

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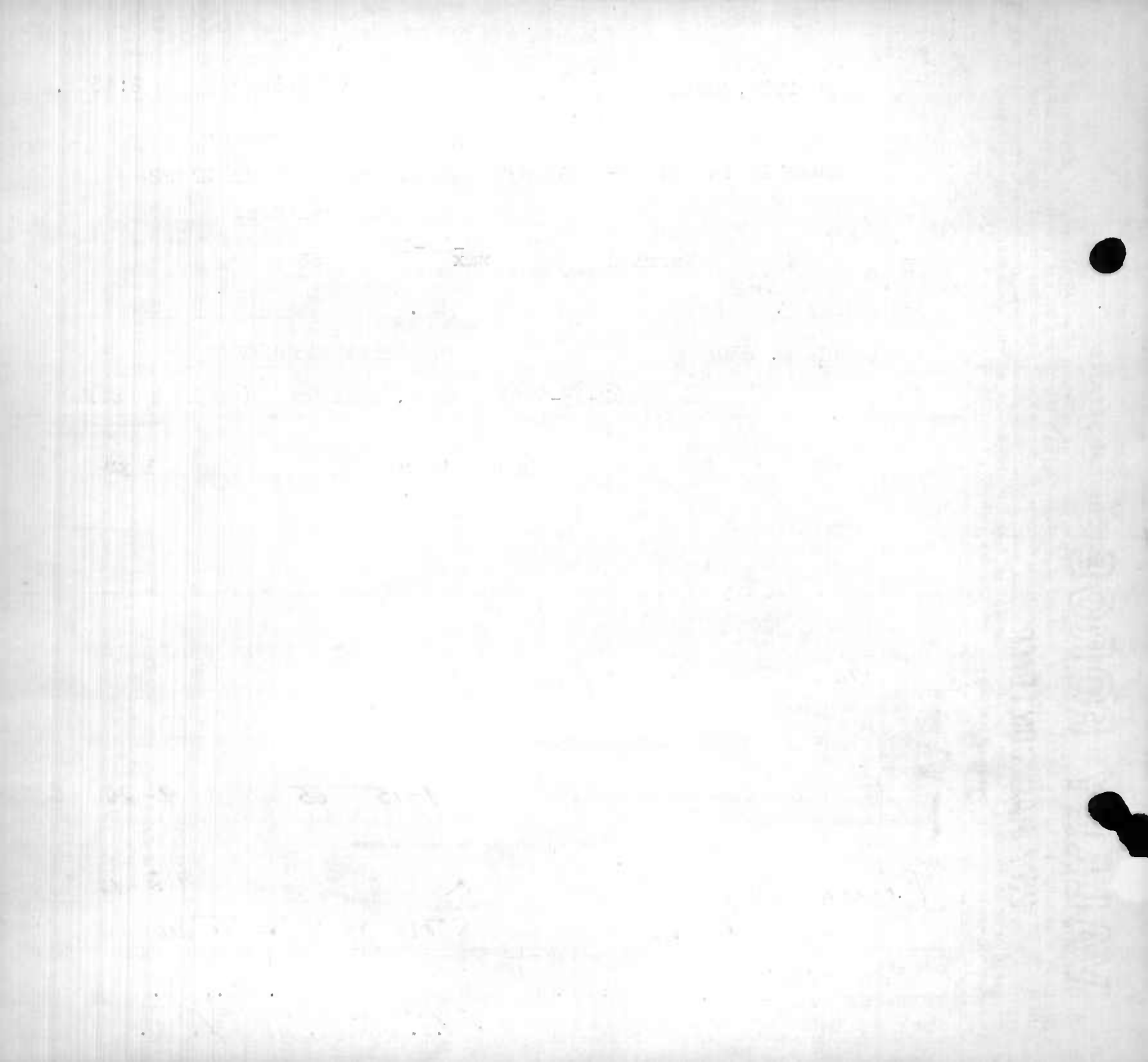
STATIONER - 10/10/10

STATIONER - 10/10/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

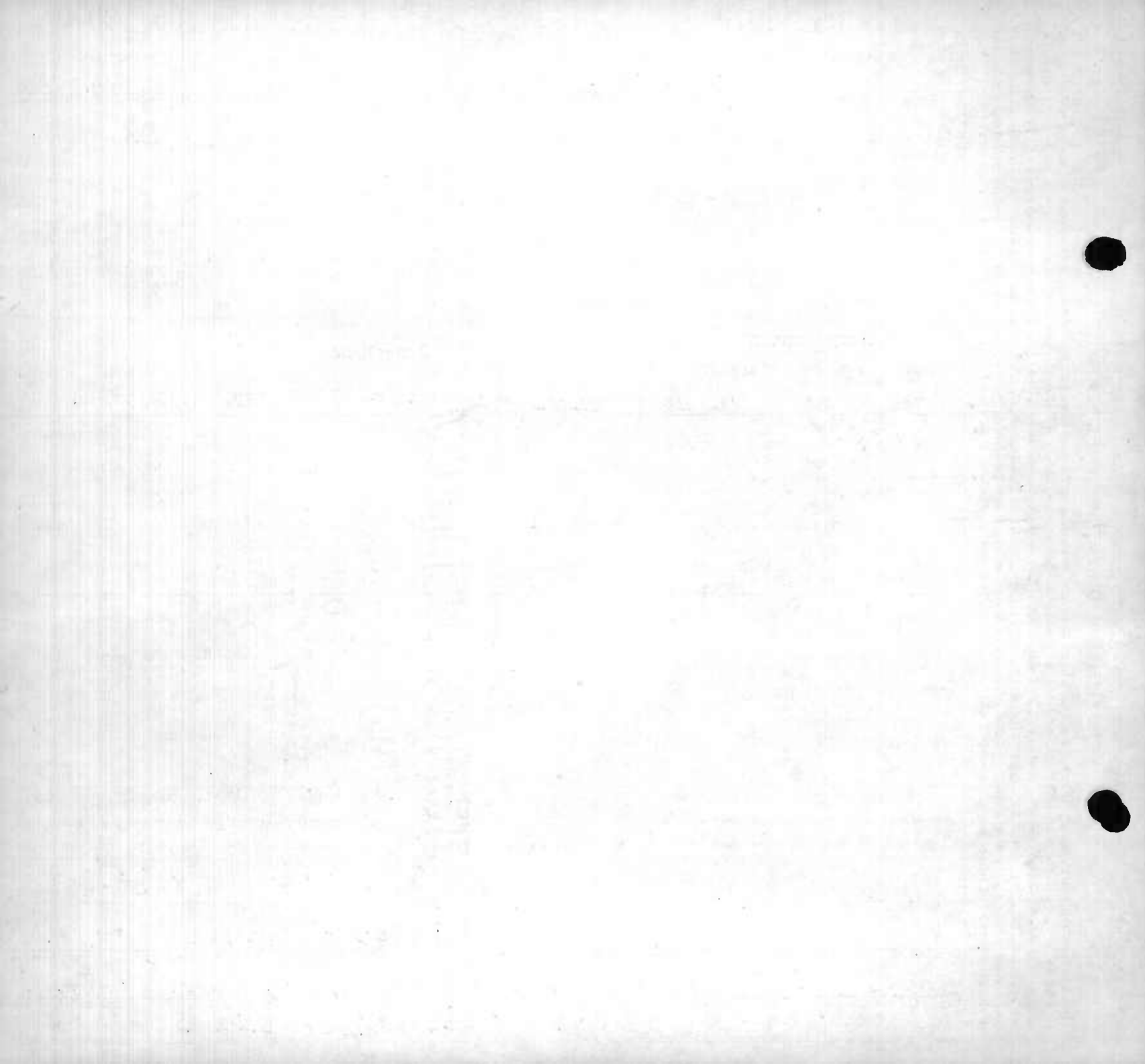
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9969 | |
|----------------------------------------------------------------------------------------------------------------------------------------------|---------|---------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------|--------------------------------------------------------|
| BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) | | 65 9969 | | CERTIFICATE OF DEATH | |
| 2. DATE AND HOUR OF DEATH | | <div style="display: flex; justify-content: space-between;"> <div>MARY RUTH BAFITIS <i>Bafitis, Ruth</i></div> <div>9/26/65 8:45 P. M.</div> </div> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| House In The Pines-Belvedere | | <div style="display: flex; justify-content: space-between;"> <div>Maryland</div> <div>BALTIMORE</div> </div> | | | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | D. STREET ADDRESS (If rural, give location) | | | |
| | | <div style="display: flex; justify-content: space-between;"> <div>DUNDALK 21222</div> <div>53-00</div> </div> | | | |
| 3482 Dunhaven Road | | | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| F | W | Married | 6-10-12 | 53 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| HOUSEWIFE | | | | KY. | |
| 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | | |
| USA | | GEORGE F. RICE | | | |
| 14. MOTHER'S MAIDEN NAME | | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | |
| TRINVILLA FAIRCHILD | | NO | | | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| 402-05-2892 | | NICK W. BAFITIS (AS IN 4 ABOVE) | | | |
| 18. 15-6.1 I | | CAUSE OF DEATH | | | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | (A) <u>Ca of Liver</u> | | | |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | DUE TO | | | |
| ANTECEDENT CAUSES | | (B) _____ | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | DUE TO | | | |
| (C) _____ | | | | | |
| II | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | 1 yr | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 0 1964 | | ca of liver | | No | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initialed medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from | | 9-15 1965 to 9-26 1965. | | | |
| that (I) (we) last saw the deceased alive on | | 19 and that in (my) (our) opinion death occurred on the date | | | |
| and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED | |
| <i>Wickerson</i> | | | | 9/28/65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| WICKERSON | | 5721 park 1641-1642 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | |
| BURIAL | | 9/29/65 | | OAKLAWN | |
| 24D. LOCATION (City, town, or county) (State) | | 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | |
| BALTO. CO., MD. | | SEP 29 1965 | | Robert E. Fairbank | |
| 25C. FUNERAL DIRECTOR ADDRESS | | 25D. FUNERAL DIRECTOR ADDRESS | | 25E. FUNERAL DIRECTOR ADDRESS | |
| W.B. BRADLEY, DUNDALK, MD. | | W.B. BRADLEY, DUNDALK, MD. | | W.B. BRADLEY, DUNDALK, MD. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

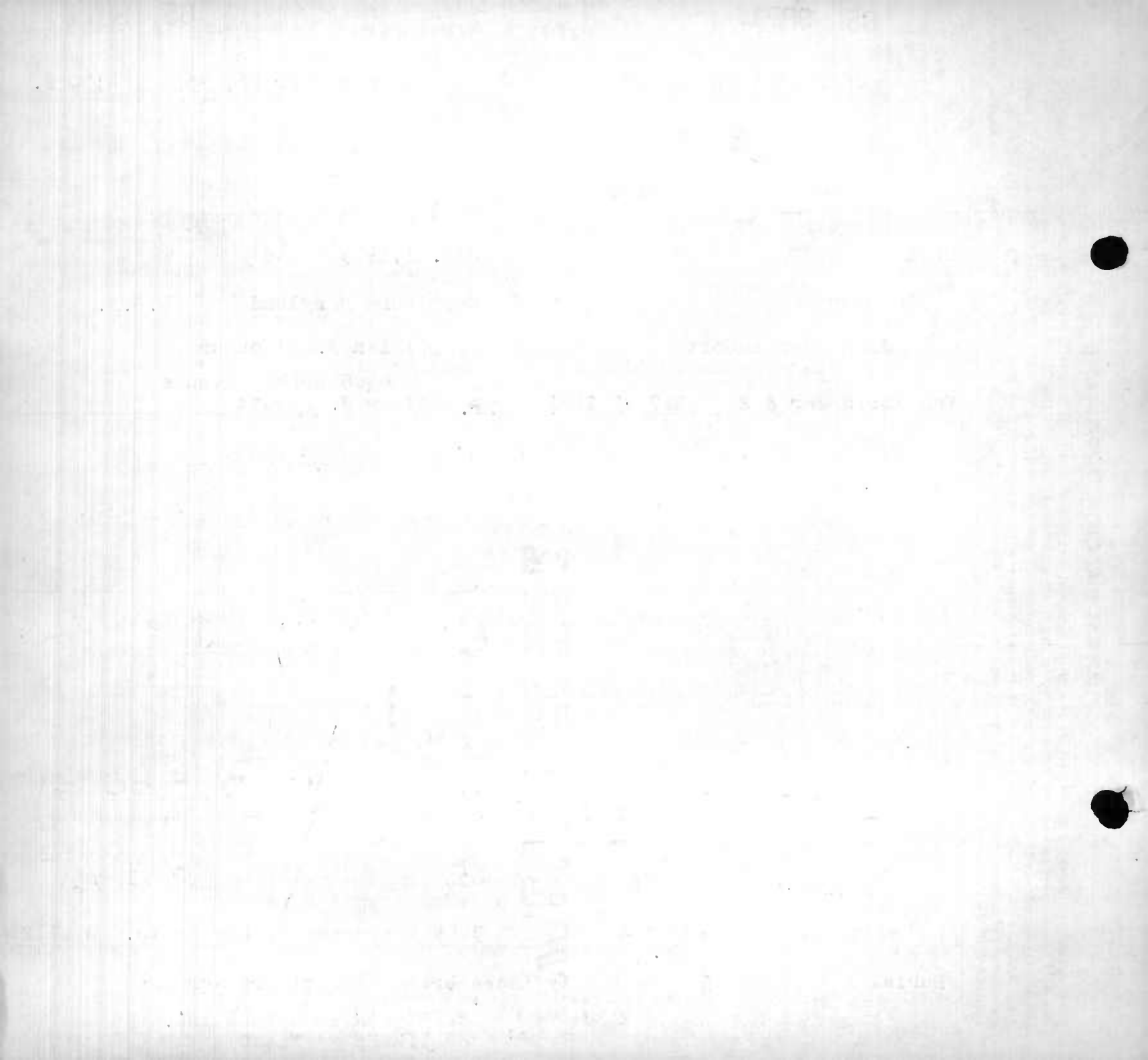
| | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|---------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--------------------------------------------------------------------------|-----------------------------------------------------------|
| BIRTH NO. 65 9970 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9970 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | X | |
| 1. NAME OF DECEASED (Type or Print) | | BIAGIO GENESIO CONTINO | | 2. DATE AND HOUR OF DEATH Sept. 28, 1965 4:45 = A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | Pa. | | Philadelphia | |
| US Public Health Service Hospital Wyman Pk. Drive & 31st St. | | D. STREET ADDRESS (If rural, give location) | | 2211 S. 11th St. | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | 8. DATE OF BIRTH 8/22/16 | 9. AGE (In years last birthday) 49 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wiper | | 10B. KIND OF BUSINESS OR INDUSTRY Seafarer | | 11. BIRTHPLACE (State or foreign country) Pa. | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Anthony Contino | | 14. MOTHER'S MAIDEN NAME Josephine ? | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes USA 1941-1945 | | 16. SOCIAL SECURITY NO. 204-05-6451 | | 17. INFORMANT Records- US PHS Hospital, Balto, Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Hepatic failure DUE TO (B) Metastatic adenocarcinoma DUE TO 1. Adenocarcinoma of colon | | INTERVAL BETWEEN ONSET AND DEATH 1 month 2 months 4 months | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Renal insufficiency | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from July 5 1965 to Sept. 28 1965, that (I) (we) last saw the deceased alive on Sept. 28 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE M.P. Krachovic | | 23B. DATE SIGNED 9-28-65 | | 23C. PHYSICIAN'S NAME (Type) | |
| M.D. | | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23D. ADDRESS M.D. US PHS Hospital, Balto, Md. | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE Oct. 2/65 | | 24C. NAME of CEMETERY or CREMATORY Holy Cross | |
| 24D. LOCATION (City, town, or county) (State) | | 24E. NAME OF REGISTRAR Robert E. Taylor | | 24F. FUNERAL DIRECTOR DeLange 322 S. High | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 29 1965 | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

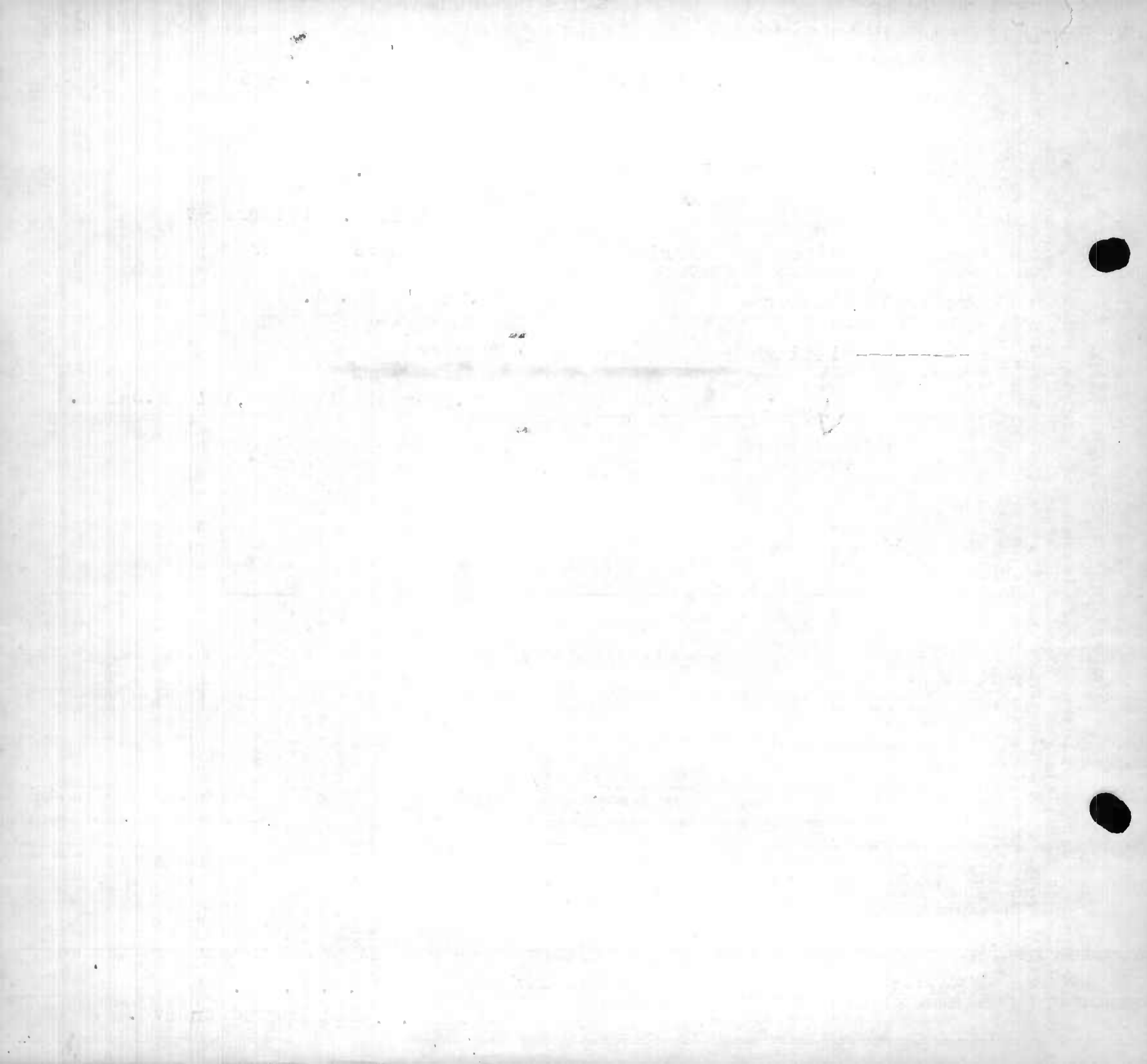
| BIRTH NO. 65 9971 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9971 | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------|------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------|
| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) JOHN MATTHEW ABBOTT | | | | 2. DATE AND HOUR OF DEATH September 26, 1965 4:30 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE MARYLAND | | B. COUNTY 27-02 | |
| 4408 ARABIA AVENUE | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 21214 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 4408 ARABIA AVENUE | | | |
| 5. SEX MALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE | 8. DATE OF BIRTH JAN. 21, 1919 | 9. AGE (In years last birthday) 46 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Die Room | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME John Adam Abbott | | | | 14. MOTHER'S MAIDEN NAME Lillian A. O'Connor | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War # 2 217 03 3479 | | | | 16. SOCIAL SECURITY NO. 03 3479 | | 17. INFORMANT ADDRESS 4408 Arabia Avenue Mr. Matthew J. Abbott | |
| 18. 4-20-1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Infarction - Myocardium ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Coronary Thrombosis | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 2 - Previous infarction - Myocardium | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (the hospital) attended the deceased from July 19 59 to Sept 26 19 65 , that (I) (the) last saw the deceased alive on Sept 15 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Donald W. Mintze | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9/28/65 | |
| 23C. PHYSICIAN'S NAME (Type) DONALD W. MINTZER | | | | 23D. ADDRESS M.D. 3009 Evergreen Avenue Balto. Md. 21214 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/30/65 | | 24C. NAME OF CEMETERY or CREMATORY Most Holy Redeemer | | 24D. LOCATION (City, town, or county) (State) Baltimore Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 29 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS INC. BALTIMORE MARYLAND | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

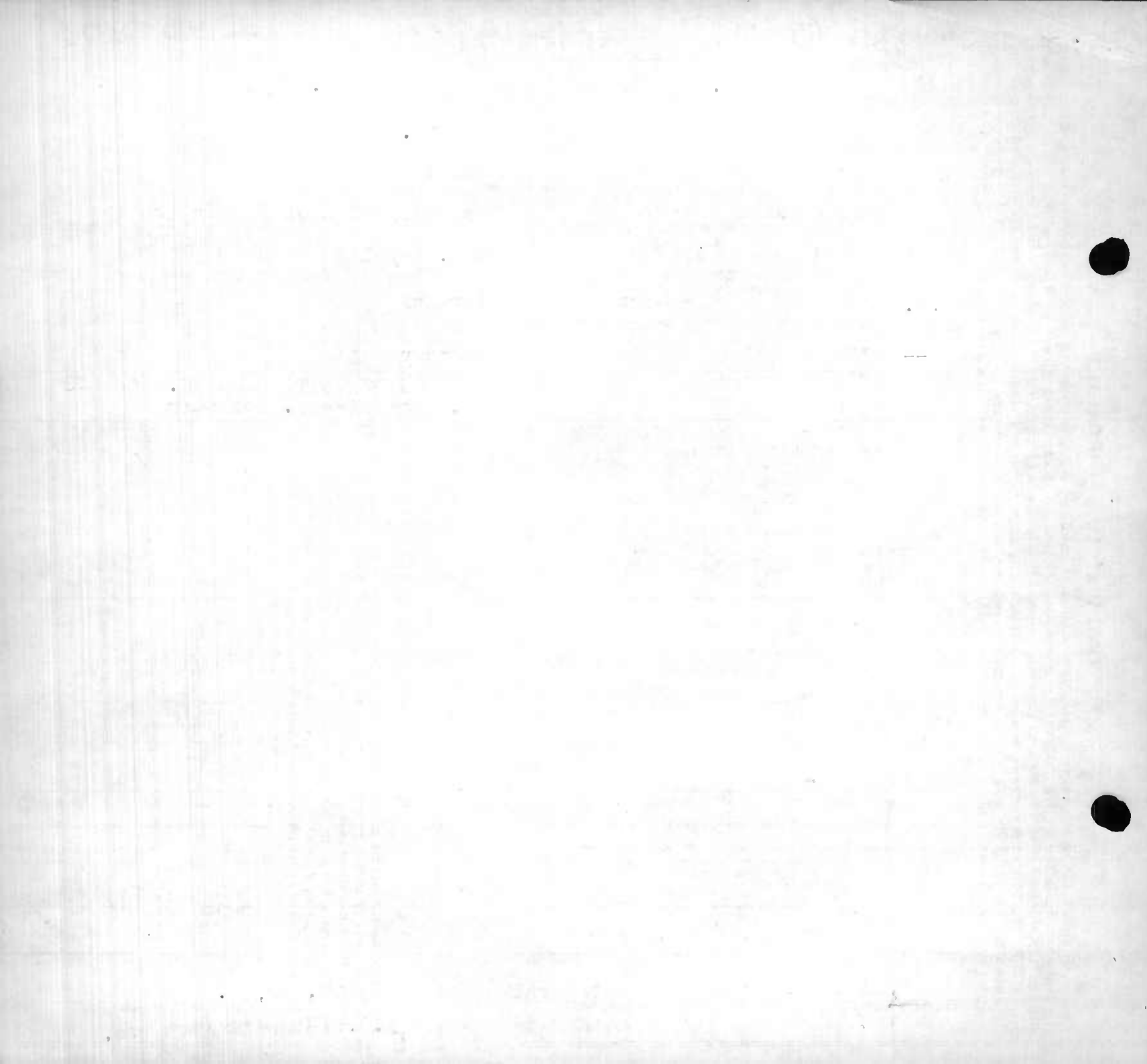
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9972 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|
| BIRTH NO. 65 9972 | | | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) Joseph A. Williams | | | 2. DATE AND HOUR OF DEATH Sept. 24/65 8 A. M. | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | 4. USUAL RESIDENCE (Where deceased lived. (If institution; residence before admission)) A. STATE Md B. COUNTY 19-02 | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1616 W. Baltimore St | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto. 23 | | |
| | | | D. STREET ADDRESS (If rural, give location) 1616 W. Baltimore St | | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) married | 8. DATE OF BIRTH March 22/96 | 9. AGE (In years last birthday) 69 | 10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Polisher | | | 11. BIRTHPLACE (State or foreign country) So. Mary's Co. Md. | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Williams | | | 14. MOTHER'S MAIDEN NAME Unknown | | |
| 15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service) 220 01 5547 | | | 16. ADDRESS 300 23 Mrs. Frances Williams, 1616 W. Baltost | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) Acute myocardial Infarction | | | CAUSE OF DEATH (A) DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. | | | (B) DUE TO | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | (C) DUE TO | | |
| 19A. DATE OF OPERATION 0 | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notably medical examined) <input type="checkbox"/> | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? |
| 22. I certify that (I) (this hospital) attended the deceased from Sept. 1963 to Sept. 24 1965 , that (I) (we) last saw the deceased alive on Sept. 23 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Morris B. Schreiber | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9-27-65 |
| 23C. PHYSICIAN'S NAME (Type) MORRIS B. SCHREIBER | | | 23D. ADDRESS 1519 W. Lombard St. Baltimore 23 Md. | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | 24B. DATE 9/29/65 | 24C. NAME of CEMETERY or CREMATORY Glen Haven | | 24D. LOCATION (City, town, or county) (State) A.A.Co. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 29 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR F.D. 4101 Edmondson Ave. | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 65 9973 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------|--|
| BIRTH NO. 65 9973 | | | | M.E. CASE NO. | | | |
| 1. NAME OF DECEASED (Type or Print) Mary R. Herbert | | | | 2. DATE AND HOUR OF DEATH Sept. 26/65 | | M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION Hoods Nursing Home 5313 Edmondson Ave | | | | A. STATE Md. B. COUNTY 16-08 | | | |
| 5. SEX Female | | | | 6. RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOW | |
| 8. DATE OF BIRTH Dec. 14/81 | | | | 9. AGE (In years last birthday) 83 | | 10. If Under 1 Yr. Months: Days: Hours: Min. | |
| 11. BIRTHPLACE (State or foreign country) Germany | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME --Ruff | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT 6203 Collinsway Rd. Zone 28 Mrs. Katherine A. Coolahan | |
| 18. 33-0X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH (A) Dehydration - malnutrition (B) Parkinson's disease (C) | | INTERVAL BETWEEN ONSET AND DEATH 1 week years | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from 19 46 to Sept 26 19 65, that (I) (we) last saw the deceased alive on Sept 24 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (do) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE H. W. Scheye | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED 9/29/65 | |
| 23C. PHYSICIAN'S NAME (Type) H. W. SCHEYE | | | | 23D. ADDRESS M.D. 710 Park Ave. - Balto, Md 21201 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) burial | | 24B. DATE 9/30/65 | | 24C. NAME OF CEMETERY or CREMATORY New Cathedral | | 24D. LOCATION (City, town, or county) (State) Balto. 29, Md. | |
| 25A. DATE REC'D BY HEALTH DEPT SEP 29 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 25C. FUNERAL DIRECTOR Witzke F.D. | | ADDRESS 4101 Edmondson Ave. | |



1
S-315

65 9974

BALTIMORE CITY HEALTH DEPARTMENT

65 9974

| BIRTH NO. _____ | | | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____ | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|-----------------------------------------------------------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------------------|--|
| M.E. CASE NO. _____ | | | | | | | |
| 1. NAME OF DECEASED (Type or Print) | | COYET STEVENSON | | 2. DATE AND HOUR PRONOUNCED DEAD | | 9-26-65 12:14 P.M. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) FRANKLIN SQUARE HOSPITAL - DOA | | | | A. STATE Maryland | | | |
| | | | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 10-01 | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 729 E. Preston Street 21213 | | | |
| 5. SEX Male | 6. RACE Colored | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. B. DATE OF BIRTH 4-24-1905 | 9. AGE (in years last birthday) 60 | If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) NORTH CAROLINA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME ? | | 14. MOTHER'S MAIDEN NAME CORNE LIA STEVENSON | | 17. INFORMANT ADDRESS JESSIE STEVENSON - 729 E. Preston St. | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II | | 16. SOCIAL SECURITY NO. 204-22-8790 | | | | | |
| 18. CAUSE OF DEATH 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | (A) Arteriosclerotic cardiovascular disease DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | (B) DUE TO | | | |
| | | | | (C) DUE TO | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED WHILE AT WORK [] NOT WHILE AT WORK [] | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that I held an Inquiry [] Inspection [X] Autopsy [] and that on this basis, death in my opinion resulted from: Natural causes [X] Accident [] Suicide [] Homicide [] Undetermined manner [] | | | | | | | |
| ACTUAL SIGNATURE | | RUSSELL S. FISHER, M.D. | | CHIEF MEDICAL EXAMINER [X] | | DATE SIGNED | |
| EXAMINER'S NAME (Type) | | | | M.D. ASSISTANT MEDICAL EXAMINER [] | | 9-27-65 | |
| ASSOCIATE MEDICAL EXAMINER [] | | | | | | | |
| 23A. BURIAL CREMATION, REMOVAL (Specify) Transit-Burial | | 23B. DATE Oct. 1, 1965 | | 23C. NAME OF CEMETERY or CREMATORY Arlington National | | 23D. LOCATION (City, town, or county) Arlington Virginia | |
| 24A. DATE REC'D BY HEALTH DEPT. SEP 29 1965 | | 24B. NAME OF REGISTRAR Robert E. Farley, M.D. | | 24C. FUNERAL DIRECTOR MARSHALL W. JONES, JR. | | ADDRESS 1735 HARFORD AVE. | |

VALLEY BOULE

1965-1966

1967-1968

1969-1970

1971-1972

1973-1974

1975-1976

1977-1978

1979-1980

1981-1982

1983-1984

1985-1986

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9975 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9975 | |
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| M.E. CASE NO. | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) SARAH LASKER | | | | 2. DATE AND HOUR OF DEATH SEPTEMBER 27, 1965 745 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital | | | | A. STATE MARYLAND B. COUNTY BALTIMORE | | | |
| | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | | |
| | | | | D. STREET ADDRESS (If rural, give location) 4909 PALMER AVE #15 | | | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED | 8. DATE OF BIRTH NOT KNOWN | 9. AGE (In years last birthday) 90 | 10. Under 1 Yr. Months Days | 11. Under 24 Hrs. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | 10B. KIND OF BUSINESS OR INDUSTRY — | | 11. BIRTHPLACE (State or foreign country) Russia | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME LOUIS | | | | 14. MOTHER'S MAIDEN NAME ROSE | | | |
| 15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service) NO | | | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT CHARLES LASKER 3007 GARRISON BLVD | |
| 18. 493X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) PNEUMONIA | | | | CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 7 days | |
| 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cerebro Vascular Accident | | | | | | 8 days | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) 650 | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 21 19 65 to SEPTEMBER 27 19 65 , that (I) (we) last saw the deceased alive on SEPTEMBER 27 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Howard H. Gendason | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED Sept. 27, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) HOWARD H. GENDASON | | | | 23D. ADDRESS M.D. Sinai Hospital, Baltimore 15, MD. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 24B. DATE 9/29/65 | | 24C. NAME OF CEMETERY or CREMATORY ROSEDALE | | 24D. LOCATION (City, town, or county) (State) BALTO 561 MD | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 29 1965 | | 25B. NAME OF REGISTRAR Robert E. Farkley | | 25C. FUNERAL DIRECTOR Sylvan S. Louis & Son, Inc | | ADDRESS 3319 Olympia Ave | |

BIRTH NO. 65 9976 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

M.E. CASE NO. _____

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|--------------------------------------------------------------------------------------------------------------|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|
| 1. NAME OF DECEASED (Type or Print) JOHN JACOBSEN | | 2. DATE AND HOUR PRONOUNCED DEAD 9/28/65 13:00 a. m. | |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD St. Joseph Hospital | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1514 N. Madeira | |
| 5. SEX male | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH April 7, 1902 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rigger | | 10B. KIND OF BUSINESS OR INDUSTRY Md. Drydock | 9. AGE (in years last birthday) 63 |
| 11. BIRTHPLACE (State or foreign country) Denmark | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME John Jacobsen | | 14. MOTHER'S MAIDEN NAME Christine Larson | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 086-12-1824 | 17. INFORMANT Frances Jacobsen - 1514 N. Madeira St. |

| | | | | |
|-------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|------------------------------------------------------------------------------------|
| MEDICAL CERTIFICATION | 1B. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Inactive rheumatic heart disease (A) DUE TO _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO _____ (C) DUE TO _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | INTERVAL BETWEEN ONSET AND DEATH | |
| | 19A. DATE OF OPERATION 2 | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20A. AUTOPSY? (Yes or No) yes | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes |
| | 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR? | |
| | 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| | ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | EXAMINER'S NAME (Type) Werner U. Spitz, M.D. M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | DATE SIGNED 9/28/65 | | | |
| | 23A. BURIAL CREMATION, REMOVAL (Specify) Burial | 23B. DATE Oct. 1, 1965 | 23C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery | 23D. LOCATION (City, town, or county) (State) Baltimore Maryland |
| 24A. DATE REC'D BY HEALTH DEPT. SEP 29 1965 | 24B. NAME OF REGISTRAR Robert E. Fisher, M.D. | 24C. FUNERAL DIRECTOR ADDRESS John C. Miller Inc-6415 Belair Rd. #6 | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>65 9977</u> | |
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| BIRTH NO. <u>65 9977</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>Samuel Garner</u> | | 2. DATE AND HOUR OF DEATH <u>Sept. 27, 1965</u> | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Franklin Square Hosp.</u> | | A. STATE <u>Maryland</u> B. COUNTY <u>19-02</u> | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> | | | |
| | | D. STREET ADDRESS (If rural, give location) <u>1500 W. Lexington St.</u> | | | |
| 5. SEX <u>Male</u> | 6. RACE <u>Negro</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u> | 8. DATE OF BIRTH <u>June 24, 04</u> | 9. AGE (In years last birthday) <u>61</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Illinois</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13. FATHER'S NAME <u>William Garner</u> | | 14. MOTHER'S MAIDEN NAME <u>Minnie Burrell</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>214-20-6143</u> | | 17. INFORMANT ADDRESS <u>Dora Garner 1500 W. Lexington St.</u> | |
| 18. <u>4-20-1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Coronary occlusion</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | CAUSE OF DEATH (A) <u>Coronary occlusion</u> DUE TO (B) <u>Arteriosclerosis & hypertension</u> DUE TO (C) <u>5000</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>Immediately</u> <u>Unknown</u> | |
| MEDICAL CERTIFICATION | | | | | |
| 19A. DATE OF OPERATION <u>0</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10-19-1965</u> to <u>9-27-1965</u> , that (I) (we) last saw the deceased alive on <u>8-16-1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Frank A. Saunders</u> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <u>9-28-65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>Frank A. Saunders</u> | | 23D. ADDRESS <u>1029 N. Stricker St.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>10/1/65</u> | | 24C. NAME of CEMETERY or CREMATORY <u>Mt Auburn Cem.</u> | |
| 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 29 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>George A. Kline 1340 N. Calhoun St.</u> | |

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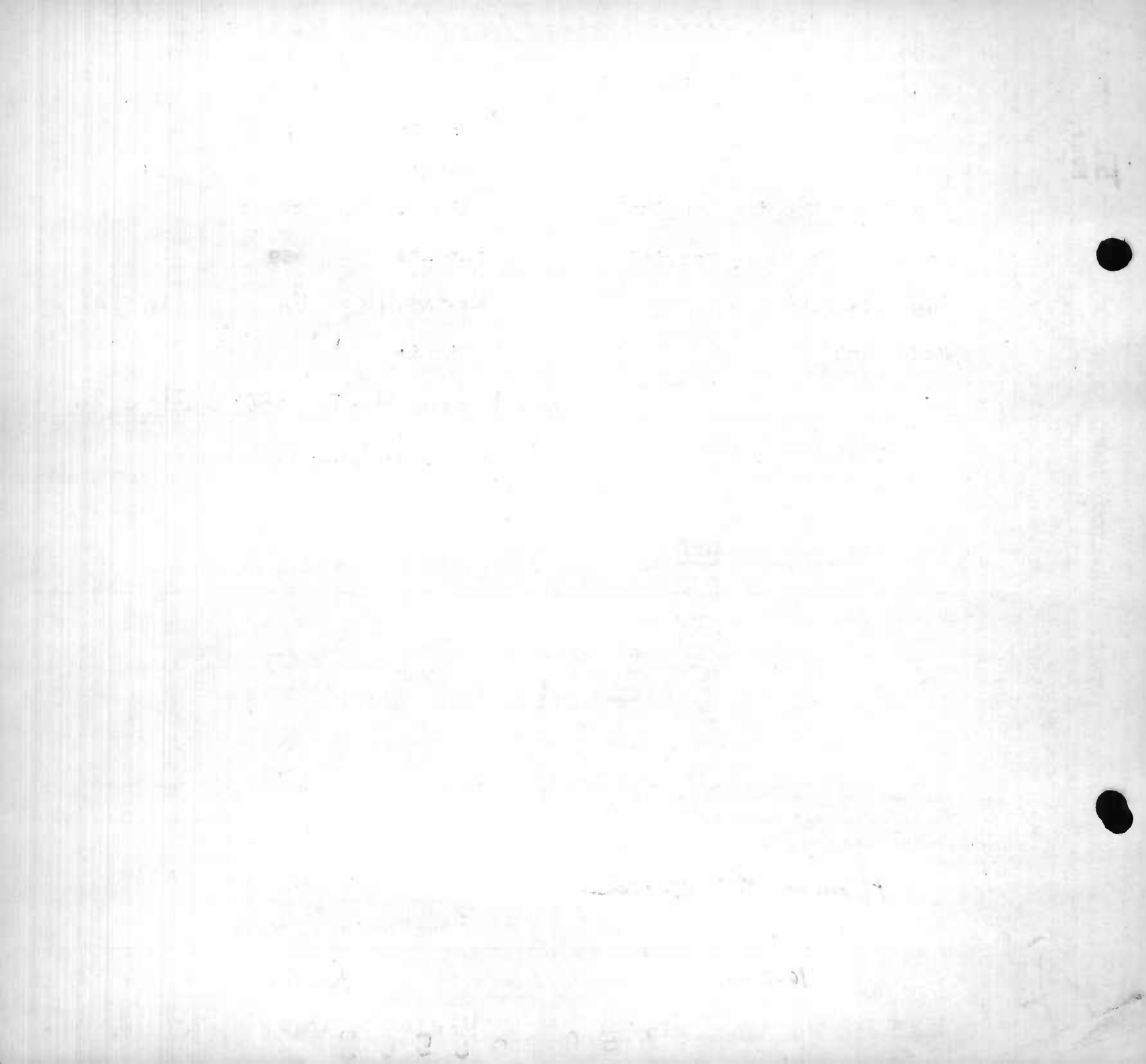
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | 65 9978 | | 65 9978 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|
| BIRTH NO. | | | | M.E. CASE NO. | | Registered No. | |
| 1. NAME OF DECEASED (Type or Print) | | | | 2. DATE AND HOUR OF DEATH | | | |
| John Thomas Hunt | | | | 9/28/65 | | 5:30A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | (If not in hospital or institution, give street address or location) | | A. STATE | | B. COUNTY | |
| The Johns Hopkins Hospital | | | | Maryland | | 3-02 | |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | | D. STREET ADDRESS (If rural, give location) | | | |
| Baltimore | | | | 130 S. Eden Street | | | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | |
| Male | | Negro | | Married | | 3-25-06 | |
| 9. AGE (In years last birthday) | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 59 | | Unemployed | | Cornsville, GA. | | U.S.A. | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| Jeff Hunt | | | | Winnie | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | 243-12-8012 | | Lizzie Hunt 130 S. Eden ST. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) | | | | CAUSE OF DEATH | | | |
| 4 22.11 | | | | (A) Arteriosclerotic cardiovascular disease | | | |
| ANTECEDENT CAUSES | | | | (B) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | (C) DUE TO | | | |
| II | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 2 | | | | YES | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/13 19 65 to 9/28 19 65, that (I) (we) last saw the deceased alive on 9/28 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | 23C. PHYSICIAN'S NAME (Type) | |
| Herman K. Gold M.D. | | | | 9/28/65 | | Herman K. Gold M.D. | |
| 23D. ADDRESS | | | | 23E. DATE OF OPERATION | | | |
| Johns Hopkins Hospital | | | | 10-2-65 | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| Burial | | 10-2-65 | | SNOWHILL | | NEWTON N.C. | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | 25D. ADDRESS | |
| SEP 29 1965 | | Robert E. Farber M.D. | | MORTON + DYETT | | 1701 Laurens | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 9979

BIRTH NO. 65 9979

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

DAISY TRUSTEE

2. DATE AND HOUR PRONOUNCED DEAD

9/27/65, 4:45 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1724 N. Bond St.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

12/13/08

9. AGE (In years
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

House Wife

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

U S A

13. FATHER'S NAME

Dolphus Eley

14. MOTHER'S MAIDEN NAME

Annie Cross

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Frances Avery 1922 E Lafayette Ave

18. 422.1

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner H. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/28/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION (City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 29 1965

Robert E. Williams

Robert E. Williams 1707 N Bond St

WILLIAM FORGE



44-70-16
P-343

65 9980

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 65 9980

| | | | | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|---------------------------------------------------------------------------------------|--|
| BIRTH NO. | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Elizabeth B. Padeletti | | 2. DATE AND HOUR OF DEATH 9-25-65 4 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224 | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 506 S. Highland Avenue #21224 | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married | 8. DATE OF BIRTH 1-11-28 27 | 9. AGE (in years last birthday) 37 38 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | 10B. KIND OF BUSINESS OR INDUSTRY At Home | | 11. BIRTHPLACE (State or foreign country) Maryland, Baltimore | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Norman Raynor | | | | 14. MOTHER'S MAIDEN NAME Marie Brune | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS RECORDS*BCH-4940 Eastern Avenue-21224 | | | |
| 18. 002,1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction DUE TO Cor Pulmonale DUE TO Severe Bilateral Covitary Tuberculosis | | | | INTERVAL BETWEEN ONSET AND DEATH 10 hours 8 years | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) No | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-13 19 65 to 9-25 19 65 , that (I) (we) last saw the deceased alive on 9-25 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Dr. K. J. McCarthy | | | | 23B. DATE SIGNED 9-25-65 | | 23C. PHYSICIAN'S NAME (Type) Dr. K. J. McCarthy | |
| 23D. ADDRESS BCH-4940 Eastern Avenue-Baltimore, Md. | | 23E. ADDRESS #21224 | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9-28-65 | | 24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery | | 24D. LOCATION (City, town, or county) (State) 7225 Eastern Blvd. Balto. Md. | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 30 1965 | | 25B. NAME OF REGISTRAR Robert E. Johnson | | 25C. FUNERAL DIRECTOR Charles S. Zailer | | 25D. ADDRESS 901 S. Conkling St. #24 | |

FUNERAL DIRECTOR: IMPORTANT

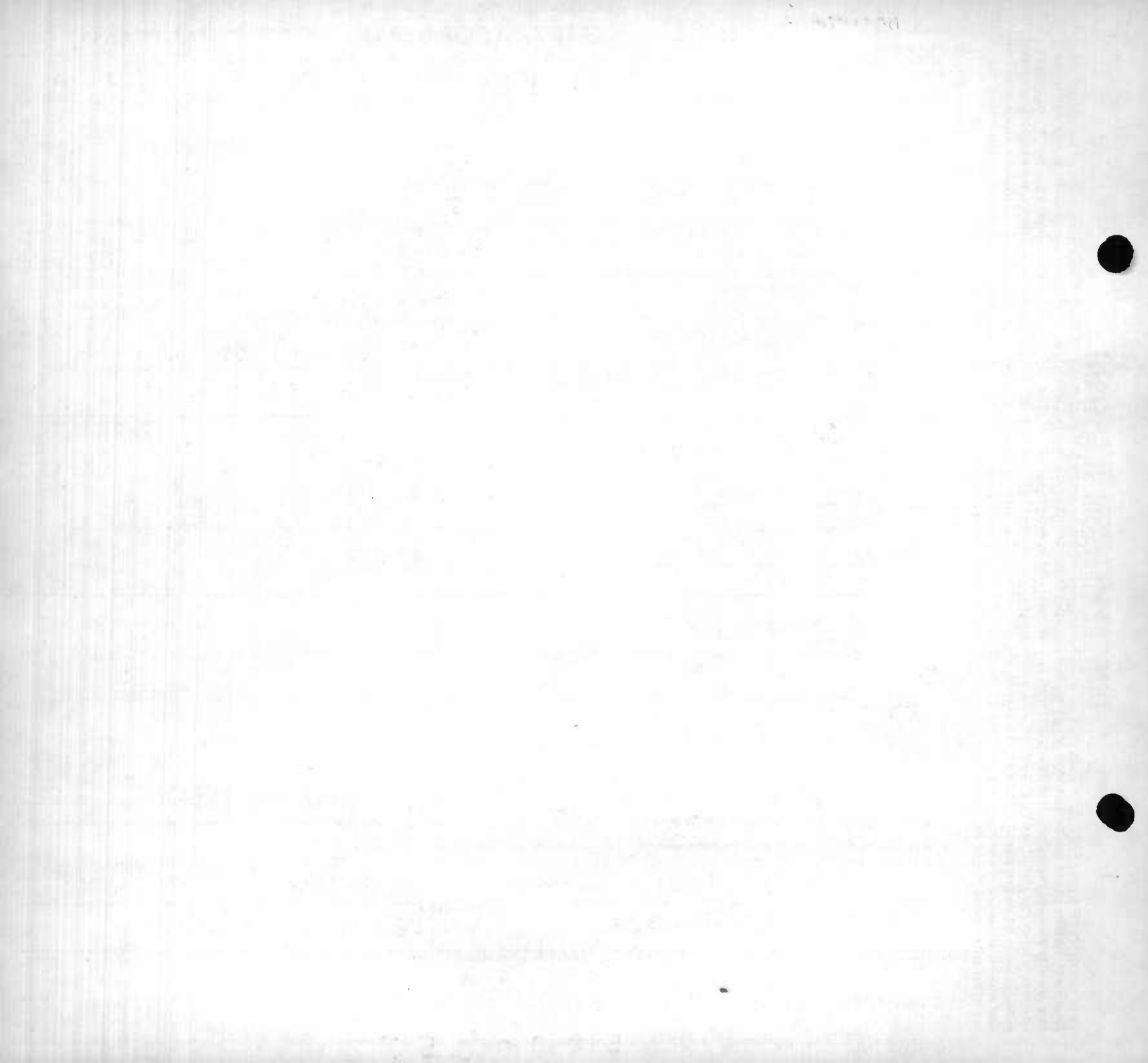
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Handwritten signature or initials, possibly "H. M. Smith".

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | BIRTH NO. 65-24245 65 9981 | | CERTIFICATE OF DEATH | | Registered No. 65 9981 | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) Baby GIM JEFFERSON | | 2. DATE AND HOUR OF DEATH 9-24-65 1.50 A.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD. B. COUNTY 14-03 | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE | | D. STREET ADDRESS (If rural, give location) 578 BAKER ST. | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL | | | | 5. SEX F 6. RACE C 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH 9-23-65 9. AGE (In years last birthday) 17 | | If Under 1 Yr. Months: Days: If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME Ann JEFFERSON - | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. - | | 17. INFORMANT ADDRESS Chart # 31-74-31 | | | |
| 18. 773.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) RESPIRATORY DISTRESS SYNDROME | | | | CAUSE OF DEATH (A) RESPIRATORY DISTRESS SYNDROME (B) OE TO (C) OE TO | | INTERVAL BETWEEN ONSET AND DEATH 17hs. | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION 9-23-65 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED - | | 20A. AUTOPSY? (Yes or No) - | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) - | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) - | | | | | |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) - | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? - | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9-23-65 to 9-24-65 , that (I) (we) last saw the deceased alive on 9-24-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Carlos Abel | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-24-65 | | | |
| 23C. PHYSICIAN'S NAME (Type) CARLOS ABEL | | | | 23D. ADDRESS UNIVERSITY HOSPITAL | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) SEP 28 1965 | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY UNIVERSITY MEDICAL SCHOOL | | 24D. LOCATION (City, town or county) (State) | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 30 1965 | | 25B. NAME OF REGISTRAR Robert E. Fisher | | 25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD | | ADDRESS | | | |



FUNERAL DIRECTOR: IMPORTANT

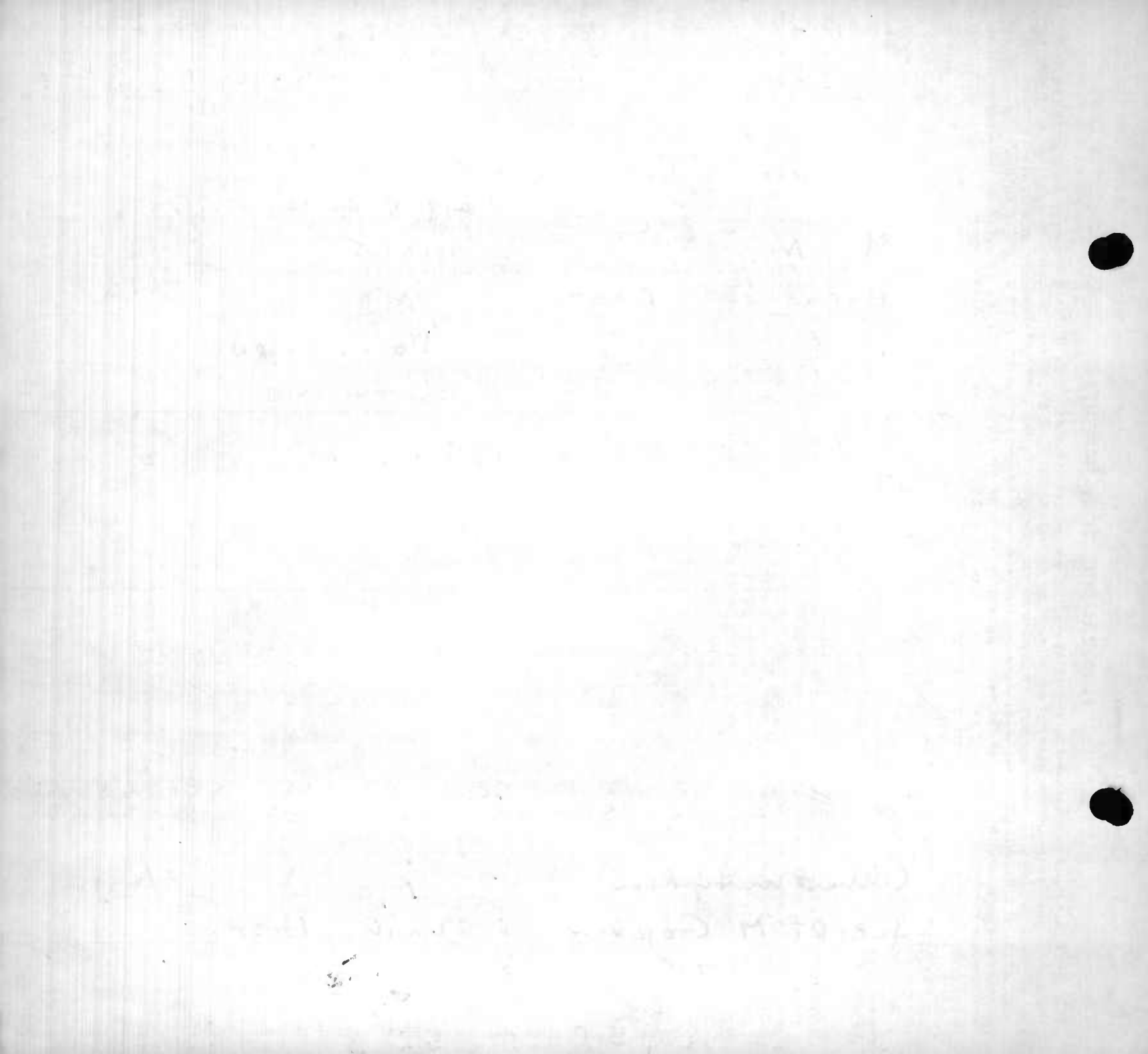
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65-24261 65 9982 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9982 | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED (Type or Print) BABY BOY TODD "A" | | | |
| 2. DATE AND HOUR OF DEATH 9/24/65 1139 A.M. | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY 14-02 | | | |
| 5. SEX M 6. RACE N 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | | | | 8. DATE OF BIRTH 9/23/65 9. AGE (In years lost birthday) 5 10. If Under 1 Yr. Months: 11. If Under 24 Hrs. Hours: 12. Min. | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BABY | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | | |
| 11. BIRTHPLACE (State or foreign country) MD. | | | | 12. CITIZEN OF WHAT COUNTRY? USA. | | | |
| 13. FATHER'S NAME ? | | | | 14. MOTHER'S MAIDEN NAME MARY ELLEN TODD. | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 0 | | | | 16. SOCIAL SECURITY NO. 0 | | | |
| 17. INFORMANT Chant # 31-66-90. | | | | ADDRESS | | | |
| 18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) IMMATUREITY | | | | INTERVAL BETWEEN ONSET AND DEATH 5 25/60 HRS. | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slotting the UNDERLYING CONDITION last. | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (1) (this hospital) attended the deceased from 9/23 1965 to 9/24 1965 , that (1) (we) lost saw the deceased alive on 9/24 1965 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Albert M. Gordon M.D. | | | | 23B. DATE SIGNED 9/24/65. | | | |
| 23C. PHYSICIAN'S NAME (Type) ALBERT M. GORDON M.D. | | | | 23D. ADDRESS UNIV. HOSP. | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE SEP 28 1965 | | 24C. NAME OF CEMETERY OR CREMATORY ANATOMY BOARD OF MARYLAND | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 30 1965 | | 25B. NAME OF REGISTRAR Robert E. Fairley | | 25C. FUNERAL DIRECTOR UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD | | ADDRESS | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Certificate of Death | | Registered No. 65 9983 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-----------------------------------------------------------------------------------------------------------|-----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|----------------------------------------------------------------------|--|
| BIRTH NO. 65-24262 65 9983 | | M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Baby boy Todd "B" | | 2. DATE AND HOUR OF DEATH 9/23/65 8:27 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 14-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. D. STREET ADDRESS (If rural, give location) 1417 N. BRUNT ST. 17 | | | |
| 5. SEX M | 6. RACE N | 7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH 9/23/65 | 9. AGE (In years last birthday) | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. 0 5 | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BABY | | 10B. KIND OF BUSINESS OR INDUSTRY BABY | | 11. BIRTHPLACE (State or foreign country) MD. | | 12. CITIZEN OF WHAT COUNTRY? USA. | |
| 13. FATHER'S NAME ? | | | | 14. MOTHER'S MAIDEN NAME DOLLY CRUDUP | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 0 | | 17. INFORMANT chart # 040739 | | ADDRESS | |
| 18. 776X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH (A) IMMATURITY DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 5 minutes | |
| | | | | (B) DUE TO | | | |
| | | | | (C) DUE TO | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (this hospital) attended the deceased from SEPT. 23 19 65 to SEPT. 23 19 65, that (we) last saw the deceased alive on SEPT. 23 19 65 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE Albert M. Gordon M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 9/23/65 | | | |
| 23C. PHYSICIAN'S NAME (Type) ALBERT M. GORDON M.D. | | | | 23D. ADDRESS ANATOMY UNIV. HOSP. BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD | | | |
| 24A. BURIAL CREMATION REMOVAL (Specify) SEP 28 1965 | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 30 1965 | | 25B. NAME OF REGISTRAR Robert E. Talley M.D. | | 25C. FUNERAL DIRECTOR | | ADDRESS | |



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

2. DATE AND HOUR PRONOUNCED DEAD

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

9. AGE (In years last birthday)

42

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Fatty liver
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/16/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

23B. DATE

SEP 28 1965

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION

(City, town or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 30 1965

Robert E. Taylor

MORTUARY SERVICE - BCHD

BCHD

WALLER HODGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|---------------------------------------------------------------------------------|------------------------------------|--|
| CERTIFICATE OF DEATH | | | | | Registered No. 65 9985 | | | | |
| BIRTH NO. | | | | | M.E. CASE NO. | | | | |
| 1. NAME OF DECEASED (Type or Print) William Sloat WILLIAM SLOAT | | | | | 2. DATE AND HOUR OF DEATH 9/18/65 7 P M. | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE SPRINGFIELD ST. HOSPITAL B. COUNTY Carroll | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY OF MARYLAND Hosp | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) SYKESVILLE, MARYLAND | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 56-00 | | | | |
| 5. SEX M | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE | | 8. DATE OF BIRTH 1/26/79 | 9. AGE (In years last birthday) 86 | If Under 1 Yr. Months: Days: Hours: Min. | | If Under 24 Hrs. Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) O | | 10B. KIND OF BUSINESS OR INDUSTRY O | | 11. BIRTHPLACE (State or foreign country) TENN | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME RATTAN SLOAT | | | | | 14. MOTHER'S MAIDEN NAME MARIANNE ? | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NOT KNOWN | | | | | 16. SOCIAL SECURITY NO. NOT KNOWN | | 17. INFORMANT ADDRESS SPRINGFIELD ST Hosp | | |
| 18. E90417 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) MYOCARDIAL INFARCTION | | | | | (A) DUE TO | | | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | | (B) FRACTURED left femur DUE TO | | | | |
| | | | | | (C) | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION O | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) SPRINGFIELD ST Hosp | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) SYKESVILLE, Md 56-00 | | | | |
| 21D. TIME OF INJURY (APPROX.) @ 8 31 65 | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> | | | 21F. HOW DID INJURY OCCUR? ? | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 9/12 19 65 to 9/18 19 65 . that (I) (we) last saw the deceased alive on 9/18 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE Bernard S. Karpers, Jr. | | | | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | 23B. DATE SIGNED 9/18/65 | |
| 23C. PHYSICIAN'S NAME (Type) Bernard S. Karpers, Jr. | | | | | 23D. ADDRESS Univ. of Md. Hosp Md. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) SEP 28 1965 | | 24B. DATE | | | 24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL | | 24D. LOCATION (City, town, or county) (State) MORTUARY SERVICE - BCHD | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 30 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | | | 25C. FUNERAL DIRECTOR ADDRESS | | | | |

Went to work

Received of shipping
Hosp

M W SINGLE 11/27/80

O O TENN

BATTIN SCAT MAR 1980

not known not known 2 years ago 27

MORGANIAN INFECTION

Fractured left femur

2/1/82 2/1/82 2/1/82

2/1/82 2/1/82 2/1/82

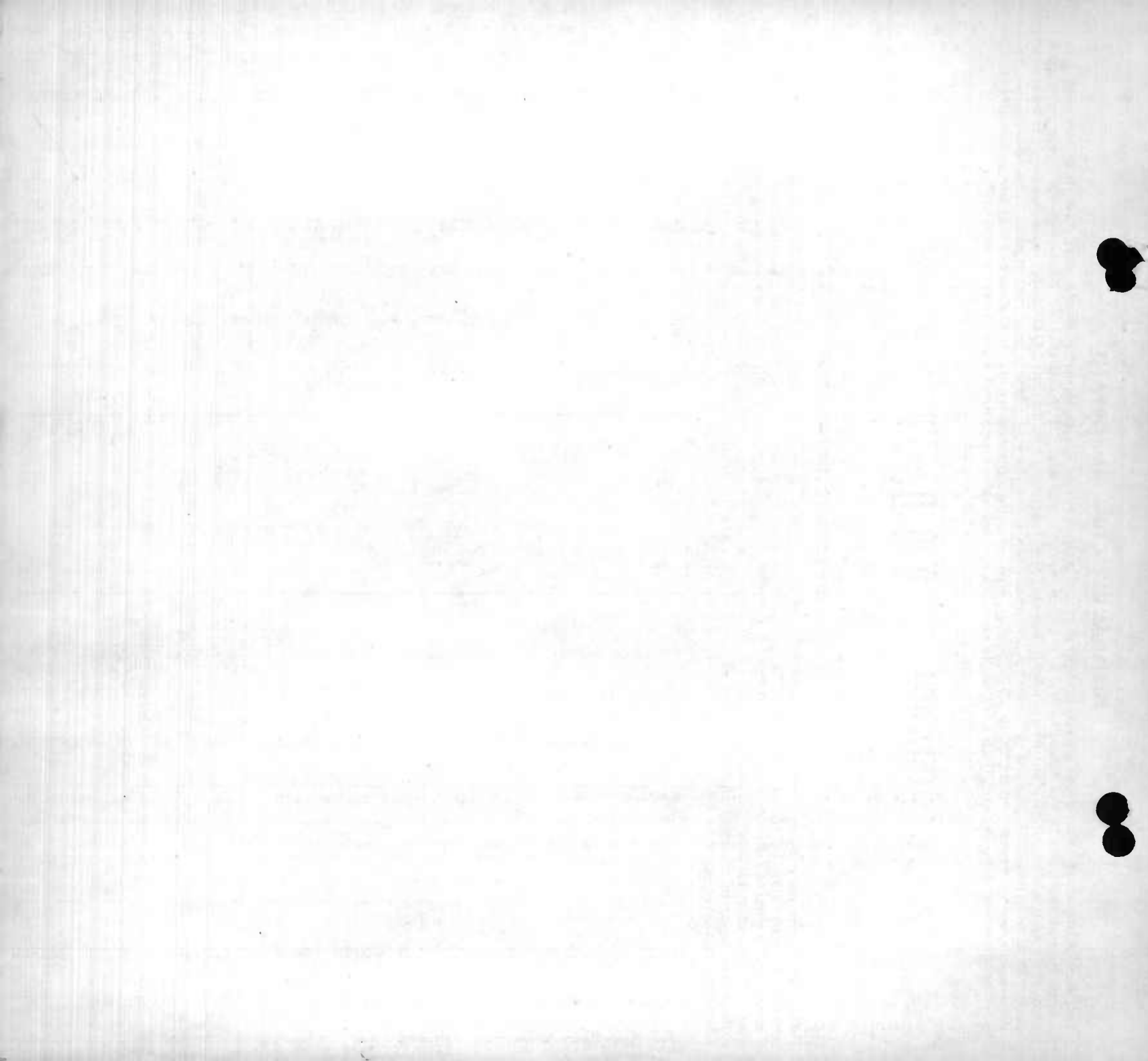
2/1/82 2/1/82 2/1/82

BETTING KAPPEL 1/1/82 1/1/82 1/1/82

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

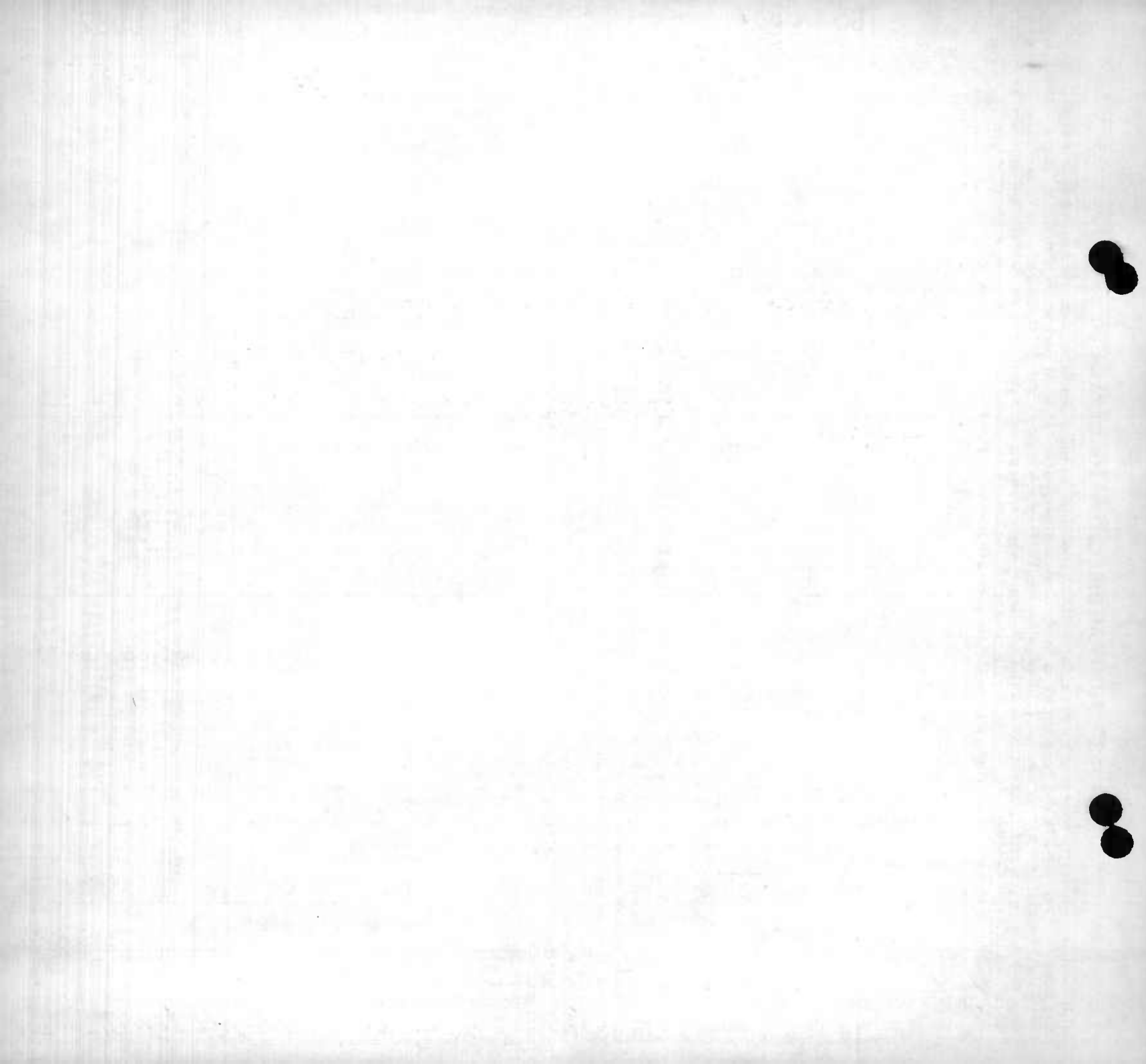
| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9986 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------------------------------------------------------------------------------------|------------------------------|--------------------------------------------------------------------------|----------------------------------------------|
| BIRTH NO. M.E. CASE NO. | | 65 9986 | | CERTIFICATE OF DEATH | |
| 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | | | |
| LEO PORTER | | Sept-19-65 5:30 P.M. | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | A. STATE B. COUNTY | | | |
| 3025 WINDSOR AVE. | | Baltimore, Md. | | | |
| | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | | |
| | | 3025 Windsor Ave. | | | |
| | | D. STREET ADDRESS (If rural, give location) | | | |
| | | 15-47 | | | |
| 5. SEX | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| M | W | | | 58 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| | | | | | |
| 13. FATHER'S NAME | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| | | | | | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| 422.1 I | | Cardio Vascular | | | |
| ANTECEDENT CAUSES | | (A) DUE TO | | | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | (B) DUE TO | | | |
| | | (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | |
| | | While At Work <input type="checkbox"/> At Work <input type="checkbox"/> | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 17 1965 to Sept 19 1965, and that (I) (we) lost saw the deceased alive on Sept 17 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | |
| M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | | | 9-19-65 | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS | | | |
| M.D. Dr. E. J. Medary | | M.D. Dr. E. J. Medary | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY OR CREMATORY | |
| | | SEP 28 1965 | | ANATOMIC BOARD OF MARYLAND | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR ADDRESS | |
| SEP 30 1965 | | Robert E. Feltner | | UNIVERSITY MEDICAL SCHOOL | |
| MORTUARY SERVICE - BCHD | | | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | CERTIFICATE OF DEATH | | Registered No. 65 9987 | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|--|
| BIRTH NO. 65 9987 | | M.E. CASE NO. 339062 | | 1. NAME OF DECEASED (Type or Print) Griffin, Irene | | 2. DATE AND HOUR OF DEATH 9/28/65 12:55 P.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 Sinai Hospital Baltimore, Md | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 8-03 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1023 Milton Ave. | | | |
| 5. SEX F | 6. RACE N | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed | 8. DATE OF BIRTH 3-15-1920 | 9. AGE (In years last birthday) 45 | If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10B. KIND OF BUSINESS OR INDUSTRY Put Family | | 11. BIRTHPLACE (State or foreign country) Holland, Georgia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Holland Johnson | | | | 14. MOTHER'S MAIDEN NAME IDA R. FRANKLIN | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 219-28-5839 | | 17. INFORMANT ADDRESS James Griffin 1023 Milton Ave | | | |
| 18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osleria, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | CAUSE OF DEATH (A) Cerebral vascular thrombosis DUE TO (B) Hypertensive encephalopathy DUE TO 3 days (C) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | | | | |
| 19A. DATE OF OPERATION 2 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) yes | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that the (this hospital) attended the deceased from 9/26 19 65 to 9/28 19 65 , that (I) was last saw the deceased alive on 9-28 19 and that in (my) and opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE J. Hertzberg | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED 9-28-65 | |
| 23C. PHYSICIAN'S NAME (Type) J. Hertzberg | | | | 23D. ADDRESS M.D. Sinai Hospital Baltimore, Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 10-2-65 | | 24C. NAME OF CEMETERY or CREMATORY Mt Auburn | | 24D. LOCATION (City, town, or county) (State) Baltimore | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 30 1965 | | 25B. NAME OF REGISTRAR Robert E. Fink | | 25C. FUNERAL DIRECTOR James Griffin | | ADDRESS 638 N. Gilman St | |



1

BALTIMORE CITY HEALTH DEPARTMENT

65 9988

BIRTH NO. 65-18074 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

JULIA ANDERSON

2. DATE AND HOUR PRONOUNCED DEAD

9/28/65 7:45 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(If not in hospital or institution, give street
address or location)

St. Joseph Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2222 N. Calvert St.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH

7/26/65

9. AGE (In years
last birthday)If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

2

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William ANDERSON

14. MOTHER'S MAIDEN NAME

Esther Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

WILLIAM ANDERSON 2222 N. CALVERT

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) Interstitial pneumonitis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT
WORKNOT WHILE
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/28/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

23B. DATE

10-2-65

23C. NAME OF CEMETERY or CREMATORY

MT. CALVARY

23D. LOCATION

(City, town, or county)

A. A. COUNTY Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

SEP 30 1965

R. E. F. F. F.

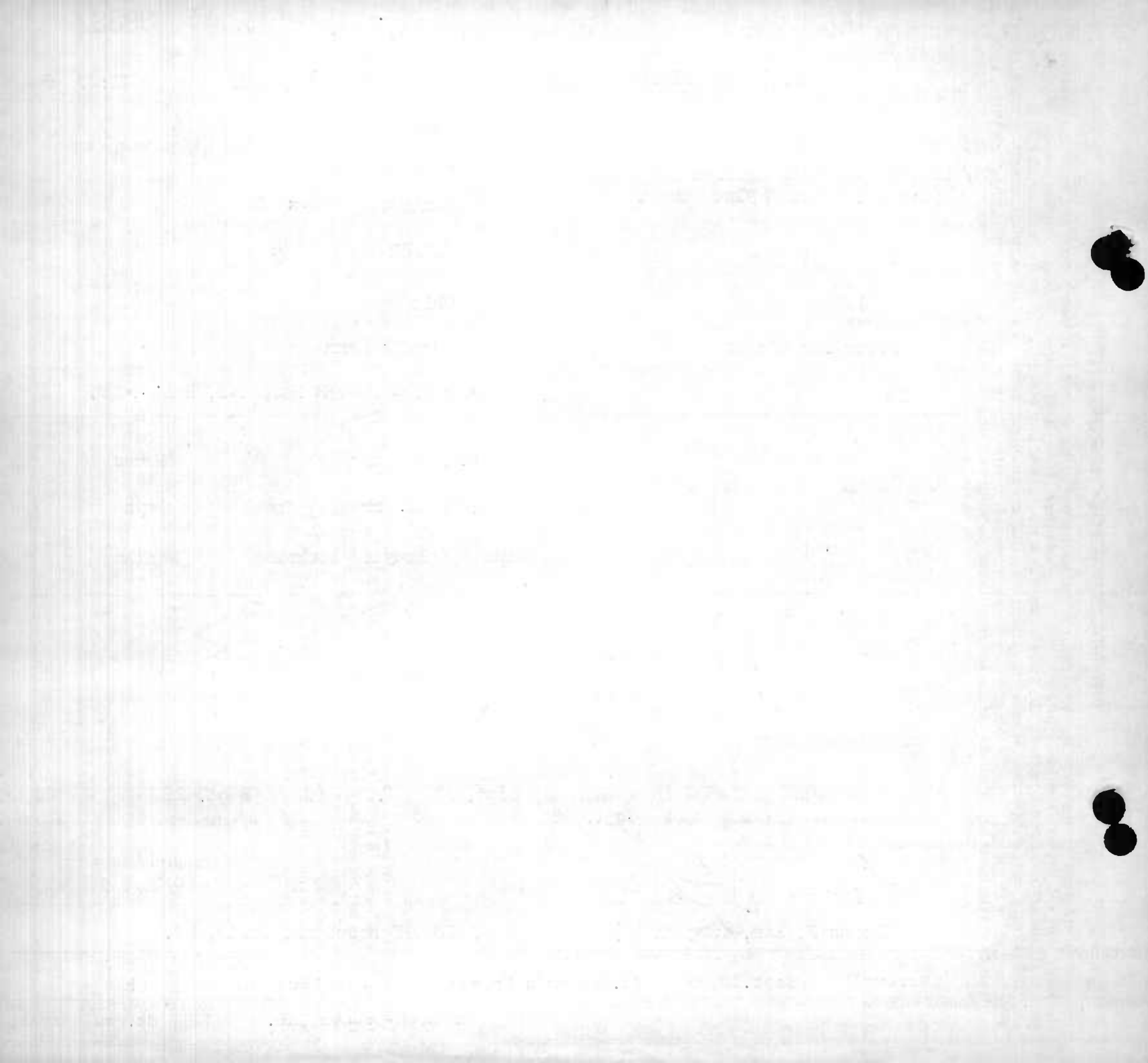
JOSEPH KNIGHT 1639 NO. BROADWAY

WILLIAM J. JOHNS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. <u>65 9989</u> | | | | BALTIMORE CITY HEALTH DEPARTMENT | | CERTIFICATE OF DEATH | | Registered No. <u>65 9989</u> | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|-------------------------------------------------------|--|
| M.E. CASE NO. | | | | 1. NAME OF DECEASED | | 2. DATE AND HOUR OF DEATH | | | |
| (Type or Print) | | | | PATRICIA ANN RICICA | | Sept. 28, 1965 | | 11:25 P M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | A. STATE | | B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION | | | | If not in hospital or institution, give street address or location | | Ohio | | | |
| US Public Health Service Hospital | | | | Wyman Pk. Drive & 31st Street | | C. CITY OR TOWN | | If outside city limits, write RURAL and give township | |
| | | | | | | Wauseon | | | |
| D. STREET ADDRESS | | | | If rural, give location | | Route 5 | | Box 26 | |
| 5. SEX | | 6. RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | |
| F | | W | | Child | | 1/12/62 | | 3 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Child | | | | | | Ohio | | USA | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| Marcellus Ricica | | | | Carole Mann | | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| No | | | | None | | Records- US PHS Hospital, Balto, Md. | | | |
| 18. <u>20431</u> | | | | CAUSE OF DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH | | | | (A) Pulmonary edema | | | | Hours | |
| (This does not mean the made al dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | | | DUE TO | | | | | |
| ANTECEDENT CAUSES | | | | (B) Pulmonary hemorrhage, focal | | | | Days | |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | DUE TO | | | | | |
| | | | | (C) Acute lymphocytic leukemia | | | | Months | |
| II | | | | | | | | | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | yes | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? | | (If in Baltimore City, give exact location) | | | |
| | | | | | | | | | |
| 21D. TIME OF INJURY (APPROX.) | | 21E. INJURY OCCURRED | | 21F. HOW DID INJURY OCCUR? | | | | | |
| (Month) (Day) (Year) (Hour) | | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept. 13 1965 to Sept. 28 1965, that (I) (we) last saw the deceased alive on Sept. 28 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE | | | | 23B. DATE SIGNED | | | | | |
| <i>Thomas J. Lau</i> | | | | 9/29/65 | | | | | |
| 23C. PHYSICIAN'S NAME (Type) | | | | 23D. ADDRESS | | | | | |
| Thomas J. Lau, Surgeon (R) | | | | US PHS Hospital, Balto, Md. | | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME of CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| Removal | | Sept. 30, 65 | | St. Caspar's Cemetery | | Wauseon, Ohio | | | |
| 25A. DATE REC'D BY HEALTH DEPT. | | 25B. NAME OF REGISTRAR | | 25C. FUNERAL DIRECTOR | | ADDRESS | | | |
| SEP 30 1965 | | Robert E. Talbot | | Wm Cook-Brooks, Inc. | | 1217 St. Paul Street | | | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|--------------------------------------------------------------------------|------------------------------------------|
| BIRTH NO. 65 9990 | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9990 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Margaret J. Cockran | | 2. DATE AND HOUR OF DEATH September 27, 1965 7:05 A. M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Marlborough Apts. 1701 Eutaw Place | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1701 Eutaw Place | | | |
| 5. SEX Female | 6. RACE White | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed | 8. DATE OF BIRTH Mar 19, 1883 | 9. AGE (In years lost birthday) 82 | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Government | | 10B. KIND OF BUSINESS OR INDUSTRY Retired | | 11. BIRTHPLACE (State or foreign country) Dublin, Ireland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Daniel McGilloway | | 14. MOTHER'S MAIDEN NAME Emily Cavanaugh | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. No Record | | 17. INFORMANT ADDRESS Leo Chenoweth 2108 Woodbourne Ave Balt. Md. | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) <i>Carcinoma of the Vulva</i> DUE TO (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from <i>Sept. 24 1965</i> to <i>Sept. 27 1965</i> , that (I) (we) last saw the deceased alive on <i>September 27 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <i>Benigno R. Lazaro</i> | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED <i>9/27/65</i> | |
| 23C. PHYSICIAN'S NAME (Type) | | 23D. ADDRESS Benigno R. Lazaro, M.D. 1819 Eutaw Place, Baltimore Md | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 9/30/65 | | 24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery | |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland | | 25A. DATE REC'D BY HEALTH DEPT. SEP 30 1965 | | | |
| 25B. NAME OF REGISTRAR <i>Robert E. Fairbank</i> | | 25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Inc 1217 St. Paul St. Baltimore, Md. 21202 | | | |

65 9991

BALTIMORE CITY HEALTH DEPARTMENT

65 9991

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

ROY O'CONNOR

2. DATE AND HOUR PRONOUNCED DEAD

September 25, 1965 2:35 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Church Home Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

11 S Linwood Ave

5. SEX

white

6. RACE

male

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

never married

8. DATE OF BIRTH

Nov. 19, 1944

9. AGE (In years
last birthday)

20

If Under 1 Yr. If Under 24 Hrs.
Months; Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Constructing

10B. KIND OF BUSINESS OR INDUSTRY

Leon Burdick

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Roy E. O'Connor

14. MOTHER'S MAIDEN NAME

Mary Wdzieczna

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown). (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

212-42-2314

17. INFORMANT

ADDRESS

Mrs. Mary O'Connor 11 S. Linwood Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Overdose of narcotics and ingestion of alcoholic
beverages

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSE OF DEATH?
Yes21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

house

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

712 S. Durham Street

21D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
9-25-65 5:00 P

21E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

narcotics

Accidental overdose of alcohol and

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Sept. 26, 1965

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Sept. 29, 1965 Sacred Heart of Jesus

23C. NAME of CEMETERY or CREMATORY

23D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

SEP 30 1965

24B. NAME OF REGISTRAR

Robert E. Farkas

24C. FUNERAL DIRECTOR

Raymond L. Kaczorowski 2525 Fleet Street

ADDRESS

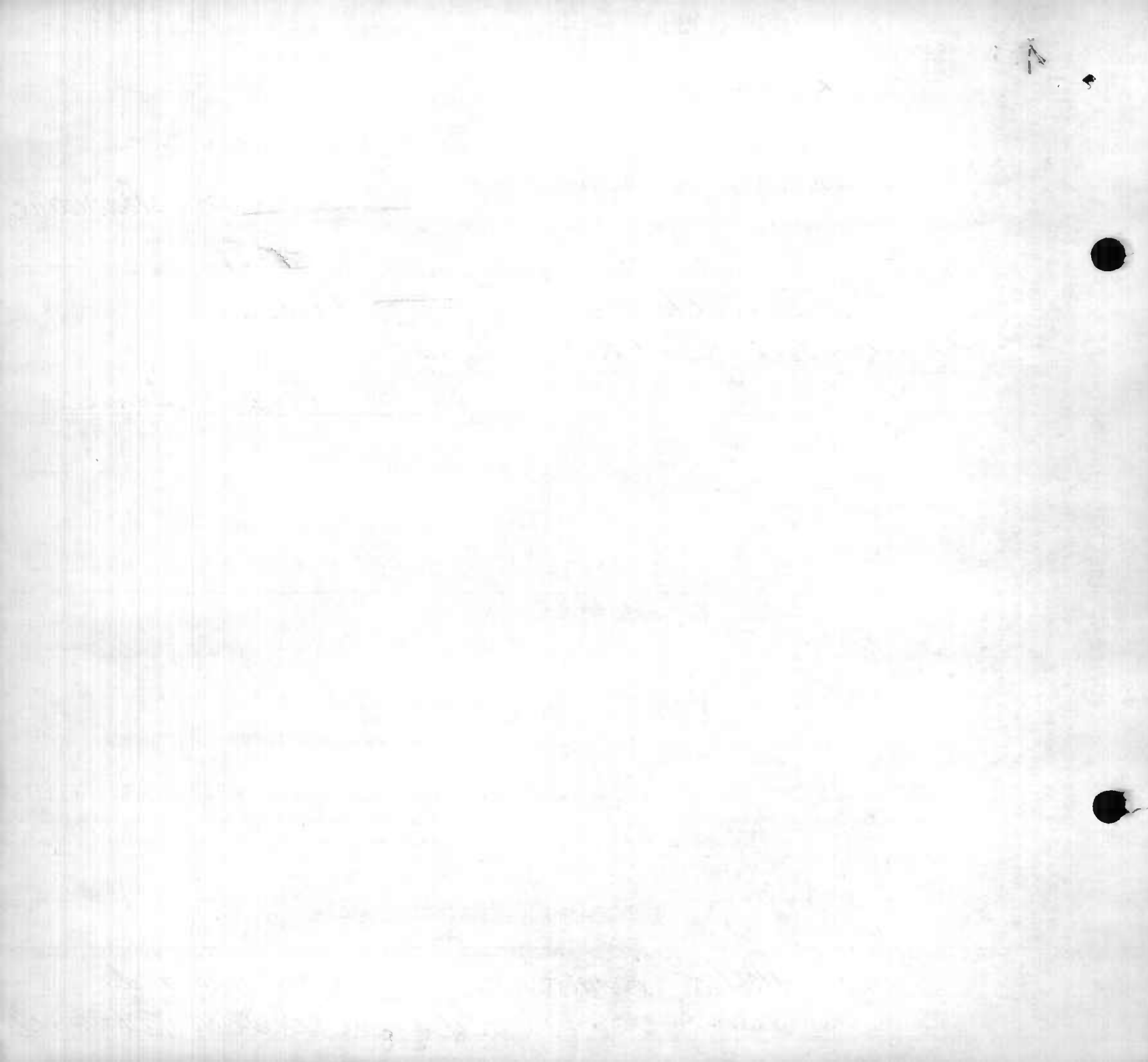
WALTER K. FIDINGE

MAINTENANCE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital, and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. <u>65 9992</u> | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|------------------|---------------------------------------------------------------------------------------------|------------------------------------------|
| BIRTH NO. <u>65 9992</u> | | CERTIFICATE OF DEATH | | | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) <u>ZELICK BECHKES</u> | | 2. DATE AND HOUR OF DEATH <u>SEPT. 26, 1965</u> <u>5⁰⁰ A</u> M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>27-20</u> | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>SINAI HOSPITAL OF BALTIMORE</u> | | D. STREET ADDRESS (If rural, give location) CALVERT AVE <u>3903 Rosencrest Ave.</u> | | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u> | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) <u>81</u> | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Reverend</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>Chickens</u> | | 11. BIRTHPLACE (State or foreign country) <u>Russia</u> | |
| 13. FATHER'S NAME <u>Morton Louis Bechkas</u> | | 14. MOTHER'S MAIDEN NAME <u>Phyllis MALAMID</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u> | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>?</u> | | 17. INFORMANT <u>PHILIP BECHKES</u> ADDRESS <u>Same</u> | |
| 18. <u>153.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <u>PNEUMONIA</u> | | CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>MALNUTRITION</u> | | (B) <u>MALNUTRITION</u> DUE TO | | | |
| | | (C) <u>CARCINOMA OF TRANSVERSE COLON</u> DUE TO | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION <u>SEPT 7-1965</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>OBSTRUCTION</u> | | 20A. AUTOPSY? (Yes or No) <u>No</u> | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u> | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u> | |
| 21D. TIME OF INJURY (APPROX.) <u>—</u> | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? <u>—</u> | |
| 22. I certify that (this hospital) attended the deceased from <u>SEPT 6</u> 19 <u>65</u> to <u>SEPT 26</u> 19 <u>65</u> and that (I) <u>last</u> saw the deceased alive on <u>SEPT 26</u> 19 <u>65</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>did</u> (did not) view the body after death. | | | | | |
| 23A. SIGNATURE <u>Allan Land</u> | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>9/26/65</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>ALLAN LAND</u> | | 23D. ADDRESS <u>SINAI HOSPITAL BALTIMORE, MD.</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24B. DATE <u>9/26/65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>Bnai Israel</u> | |
| | | | | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 30 1965</u> | | 25B. NAME OF REGISTRAR <u>Robert E. Farley, M.D.</u> | | 25C. FUNERAL DIRECTOR <u>Sh. Lerman Bros. 6000 Restoration Rd.</u> | |



CERTIFICATE OF DEATH

Registered No.

65 9993

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED
(Type or Print)

Albert J. Grossman

2. DATE AND HOUR OF DEATH

9/22/65 6:15 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF
HOSPITAL OR
INSTITUTION (If not in hospital or institution, give street
address or location)University Hospital
Green St.
Baltimore, Md 21201

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE B. COUNTY

MARYLAND 28-41

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

3611 MARMON AVE

5. SEX

MALE

6. RACE

WHITE

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

9. AGE (In years)

69

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Sanitarian

10B. KIND OF BUSINESS OR INDUSTRY

Health Dept

11. BIRTHPLACE (State or foreign country)

Romania Russia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Samuel Grossman

14. MOTHER'S MAIDEN NAME

Toby Singer

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

yes

WW II

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

MRS. ROSE GROSSMAN 3611 MARMON AVE

18. 200.1 I

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) DUE TO

lymphosarcoma

diagnosed 5/28/65

ANTECEDENT CAUSES

(B) DUE TO

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

no

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~the~~ (this hospital) attended the deceased from 9/13 19 65 to 9/22 19 65,
that ~~the~~ (we) last saw the deceased alive on 9/22 19 65 and that in ~~my~~ (our) opinion death occurred on the date
and hour and from the causes stated above. ~~(We)~~ (We) (did ~~not~~) view the body after death.

23A. SIGNATURE

Susan L. Howard, M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

9/22/65

23C. PHYSICIAN'S
NAME (Type)

SUSAN L. HOWARD

M.D.

23D. ADDRESS

SINAI HOSPITAL

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

9/23/65

24C. NAME of CEMETERY or CREMATORY

SHAAREI TFILOH

24D. LOCATION

(City, town, or county)

(State)

BALTIMORE, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

SEP 30 1965

25B. NAME OF REGISTRAR

Robert E. Fink

25C. FUNERAL DIRECTOR

ADDRESS

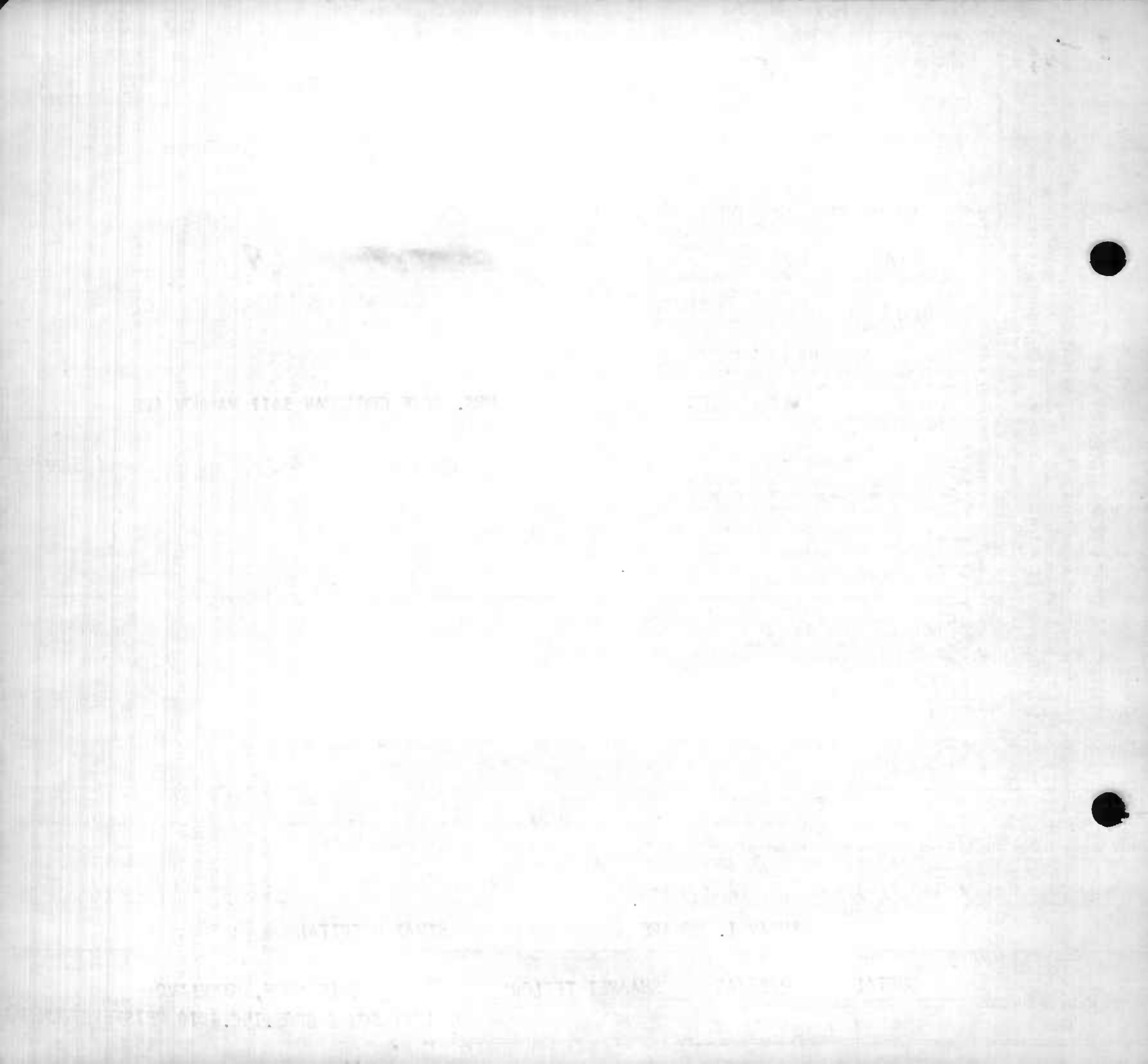
SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FOR 6960

484-1667



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------------------------------------------------------------------|------------------|--------------------------------------------------------------------------|-------------------------------------------------------------|
| BIRTH NO. | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9994 | |
| M.E. CASE NO. | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) | | IRENE S. ELY | | 2. DATE AND HOUR OF DEATH 9-27-65 1 8 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY | | MARYLAND | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) | | BALTIMORE | |
| 90 Sould Nursing Home | | D. STREET ADDRESS (If rural, give location) | | 5310 LYNVIEW AVENUE | |
| 5. SEX FEMALE | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED, SEPARATED, MARRIED | 8. DATE OF BIRTH | 9. AGE (In years lost birthday) 31 | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10B. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| HOUSEWIFE | | AT HOME | | BALTIMORE MARYLAND | |
| 13. FATHER'S NAME HARRY SCHWARTZ | | 14. MOTHER'S MAIDEN NAME MINNIE ? | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT MR. MILTON ELY | |
| | | | | ADDRESS 5310 LYNVIEW AVENUE | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) DUE TO Hodgkin's Disease (B) DUE TO (C) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 1957-1965 | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from May 1965 to 9-27-1965, that (I) (we) last saw the deceased alive on 9-26-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. yes - | | | | | |
| 23A. SIGNATURE Louis Krause | | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> | | 23B. DATE SIGNED Sept 27, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) LOUIS KRAUSE | | 23D. ADDRESS 11 E. CHASE ST | | | |
| 24A. BURIAL CREMATION, REMAINS (Specify) BURIAL | | 24B. DATE 9/29/65 | | 24C. NAME of CEMETERY or CREMATORY BETH ISAAC ADATH ISRAEL | |
| 24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | | 25A. DATE REC'D BY HEALTH DEPT. SEP 30 1965 | | 25B. NAME OF REGISTRAR Robert E. Taylor | |
| 25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD | | 25D. ADDRESS | | | |

1942

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SALTINE MARSH

DEATH

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 9995 | | | | BALTIMORE CITY HEALTH DEPARTMENT | | Registered No. 65 9995 | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|-----------------------------------------------------------------------------|-----------------------------|
| M.E. CASE NO. R 152 | | | | CERTIFICATE OF DEATH | | | |
| 1. NAME OF DECEASED (Type or Print) <u>RABINOWITZ</u> | | | | 2. DATE AND HOUR OF DEATH <u>SEPT. 27, 1965 12:30 A.M.</u> | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND CERTIFICATE AMENDED 10-19-65 <u>SINAI HOSPITAL OF BALTIMORE, INC</u> | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>27-22</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>6109 PARK HEIGHTS AVENUE</u> | | | |
| 5. SEX <u>MALE</u> | 6. RACE <u>CAUCASIAN</u> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>MAY 6, 1997</u> | 9. AGE (In years last birthday) <u>68</u> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u> | | 10B. KIND OF BUSINESS OR INDUSTRY <u>RETAIL</u> | | 11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>SAMUEL G. RABINOWITZ</u> | | | | 14. MOTHER'S MAIDEN NAME <u>LENA H. SCHRAGUS</u> | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>213-18-2061</u> | | 17. INFORMANT ADDRESS <u>MRS. BIRDIE RABINOWITZ 6109 PARK HEIGHTS AVE</u> | | | |
| 18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>170X I</u> <u>PANCREATIC CARCINOMA - METASTASES</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>7 MONTHS</u> | | | |
| II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>BREAST CARCINOMA</u> | | | | <u>7 YEARS</u> | | | |
| 19A. DATE OF OPERATION <u>FEB. 20, 1965</u> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>PANCREATIC CARCINOMA</u> | | 20A. AUTOPSY? (Yes or No) <u>NO</u> | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I certify that (I) (this hospital) attended the deceased from <u>Aug. 31</u> 19 <u>65</u> to <u>SEPT. 27</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>SEPT. 27</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | | | |
| 23A. SIGNATURE <u>Herbert Fellerman</u> | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <u>Sept 27, 1965</u> | |
| 23C. PHYSICIAN'S NAME (Type) <u>HERBERT FELLERMAN</u> | | | | 23D. ADDRESS <u>SINAI HOSPITAL</u> | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24B. DATE <u>9/29/65</u> | | 24C. NAME OF CEMETERY or CREMATORY <u>(ANSHE EMUNAH)-AITZ CHAIM</u> | | 24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u> | |
| 25A. DATE REC'D BY HEALTH DEPT. <u>SEP 30 1965</u> | | 25B. NAME OF REGISTRAR <u>Herbert Fellerman</u> | | 25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS. INC. 6010 REIST. RD</u> | | | |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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| BIRTH NO. 65 9996 | | BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH | | Registered No. 65 9996 | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) Whebe, Laurene | | 2. DATE AND HOUR OF DEATH Sept 27, 1965 11 15 A.M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE N.Y. B. COUNTY V-29 C. CITY OR TOWN (If outside city limits, write RURAL and give township) NEW YORK CITY, NY. D. STREET ADDRESS (If rural, give location) 969 Park Ave. | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital | | (If not in hospital or institution, give street address or location) | | | |
| 5. SEX F | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED | 8. DATE OF BIRTH 5-10-24 | 9. AGE (In years lost birthday) 41 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) LEBANON | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME James Bokhair | | 14. MOTHER'S MAIDEN NAME Anna Zambi | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | 17. INFORMANT DR. L. BOKHAIR | | ADDRESS PARK AVE. N.Y., N.Y. |
| 18. 1538 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | CAUSE OF DEATH (A) Hepatic Failure DUE TO (B) Liver metastasis DUE TO (C) CA of colon | | INTERVAL BETWEEN ONSET AND DEATH | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | |
| 19A. DATE OF OPERATION 0 | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) NO | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept 25 19 65 to Sept 27 19 65 . that (I) (we) last saw the deceased alive on Sept 27 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. | | | | | |
| 23A. SIGNATURE Bruce W Weissman M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | | | 23B. DATE SIGNED 9/27/65 | |
| 23C. PHYSICIAN'S NAME (Type) BRUCE W WEISSMAN M.D. | | 23D. ADDRESS J H H | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | 24B. DATE 10/1/65 | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) Cleveland, Ohio | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 30 1965 | | 25B. NAME OF REGISTRAR Robert E. Farley | | 25C. FUNERAL DIRECTOR MITCHELL-WIEDEFELD FUN. HOME - 6500 YORK RD. BALTO. 12, MD. | |
| VS 150-REV. 1/1/65 | | | | | |

REDEDI FUN HOME CLEVELAND OHIO

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | | | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------|--|-----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|----------------------------------------------------------|--|----------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------|--|--|
| BIRTH NO. 65 9997 | | | | | CERTIFICATE OF DEATH | | | | | Registered No. 65 9997 | | | | |
| 1. NAME OF DECEASED (Type or Print) Samuel Joseph Smith | | | | | 2. DATE AND HOUR OF DEATH 9/27/65 7:45 P.M. | | | | | | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | | | | | | | | | |
| FULL NAME OF HOSPITAL OR INSTITUTION University Hospital Green St., Baltimore | | | | | A. STATE Maryland B. COUNTY Baltimore city | | | | | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 21224 | | | | |
| | | | | | D. STREET ADDRESS (If rural, give location) 1634 Malvern St 26-36 | | | | | | | | | |
| 5. SEX W | | 6. RACE M | | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) married | | 8. DATE OF BIRTH 4/2/06 | | 9. AGE (In years last birthday) 59 | | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) maintenancer | | | | | 10B. KIND OF BUSINESS OR INDUSTRY Md. Drydock | | | | | 11. BIRTHPLACE (State or foreign country) Maryland | | | | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | 13. FATHER'S NAME Charles Smith | | | | | 14. MOTHER'S MAIDEN NAME Mary Elizabeth Kondyle | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no | | | | | 16. SOCIAL SECURITY NO. 218-03-2126 | | | | | 17. INFORMANT ADDRESS Wife, Mrs. Sylvia Smith, #4, a, b, c, d. | | | | |
| 18. 296X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Sepsis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. thrombocytopenia, anemia or blood dyscrasia, et.? | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | | | | | | | | | | |
| 19A. DATE OF OPERATION 2 none | | | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20A. AUTOPSY? (Yes or No) Yes | | | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no | | | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | | | 21F. HOW DID INJURY OCCUR? | | | | | | |
| 22. I certify that (this hospital) attended the deceased from 8/30 1965 to 9/27 1965 , that (we) last saw the deceased alive on 9/27 1965 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 23A. SIGNATURE Susan L. Howard, M.D. | | | | | | | | | | 23B. DATE SIGNED 9/27/65 | | | | |
| 23C. PHYSICIAN'S NAME (Type) Susan L. Howard MD | | | | | | | | | | 23D. ADDRESS University Hospital, Baltimore, Md. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | | | 24B. DATE 10-1-1965 | | 24C. NAME of CEMETERY or CREMATORY Loudon Park | | | | 24D. LOCATION (City, town, or county) (State) Frederick Rd. Balto. Md. | | | | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 30 1965 | | | | 25B. NAME OF REGISTRAR Robert E. Farley, M.D. | | | | 25C. FUNERAL DIRECTOR ADDRESS JOHN J. DUDA 7922 Wise Ave. Dundalk, Md. 21222 | | | | | | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____

BIRTH NO. _____

M.E. CASE NO. _____

1. NAME OF DECEASED

(Type or Print)

RONALD TRIBBLE

2. DATE AND HOUR PRONOUNCED DEAD

September 28, 1965 4:13 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore Dundalk

D. STREET ADDRESS (If rural, give location)

2809 Kirkleigh Road 21222

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED
WIDOWED, DIVORCED (specify)

Never Married

8. DATE OF BIRTH

Nov. 1 1954

9. AGE (In years
last birthday)

10

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

No

10B. KIND OF BUSINESS OR INDUSTRY

Student

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Tribble

14. MOTHER'S MAIDEN NAME

Margaret Ramsey

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL
SECURITY NO.

No

17. INFORMANT

Father. Joseph Tribble, #4.a.b.c.d.

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) Multiple traumatic injuries
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CAUSATION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)

street

21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)

Peninsula Expressway near Stansbury Rd.

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

9-28-65 4:01 P

m.

21E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Pedestrian struck by auto

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Rudiger Breitenecker, M.D.

CHIEF MEDICAL EXAMINER ☐
M.D. ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

9/29/65

23A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

23B. DATE

Oct. 1 1965

23C. NAME of CEMETERY or CREMATORY

Moreland Mem. Park

23D. LOCATION

(City, town, or county)

(State)

Taylor Ave. Balto. Co. Md.

24A. DATE REC'D BY HEALTH DEPT.

SEP 30 1965

24B. NAME OF REGISTRAR

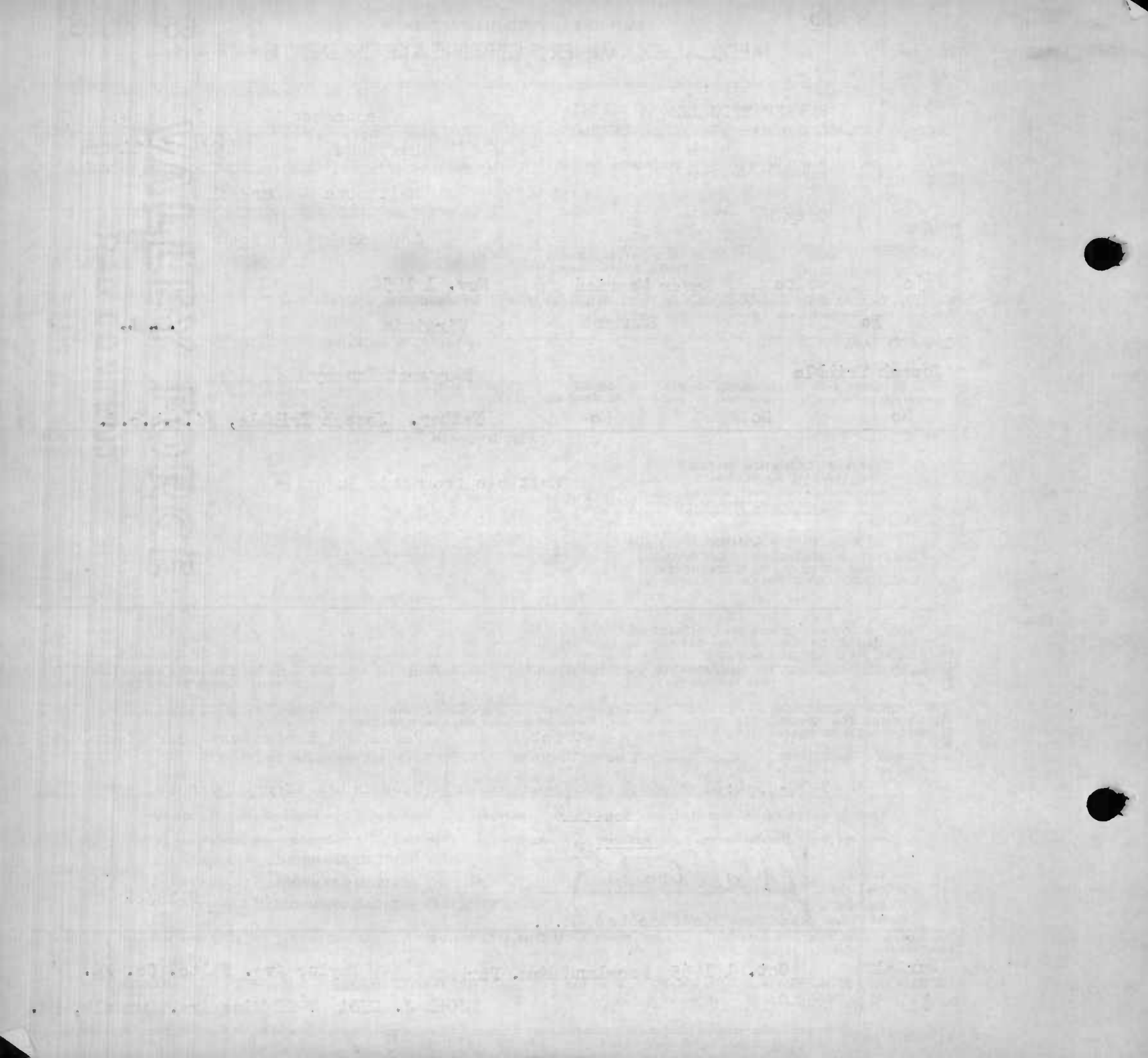
Robert E. Talley, M.D.

24C. FUNERAL DIRECTOR

JOHN J. DUDA

24D. ADDRESS

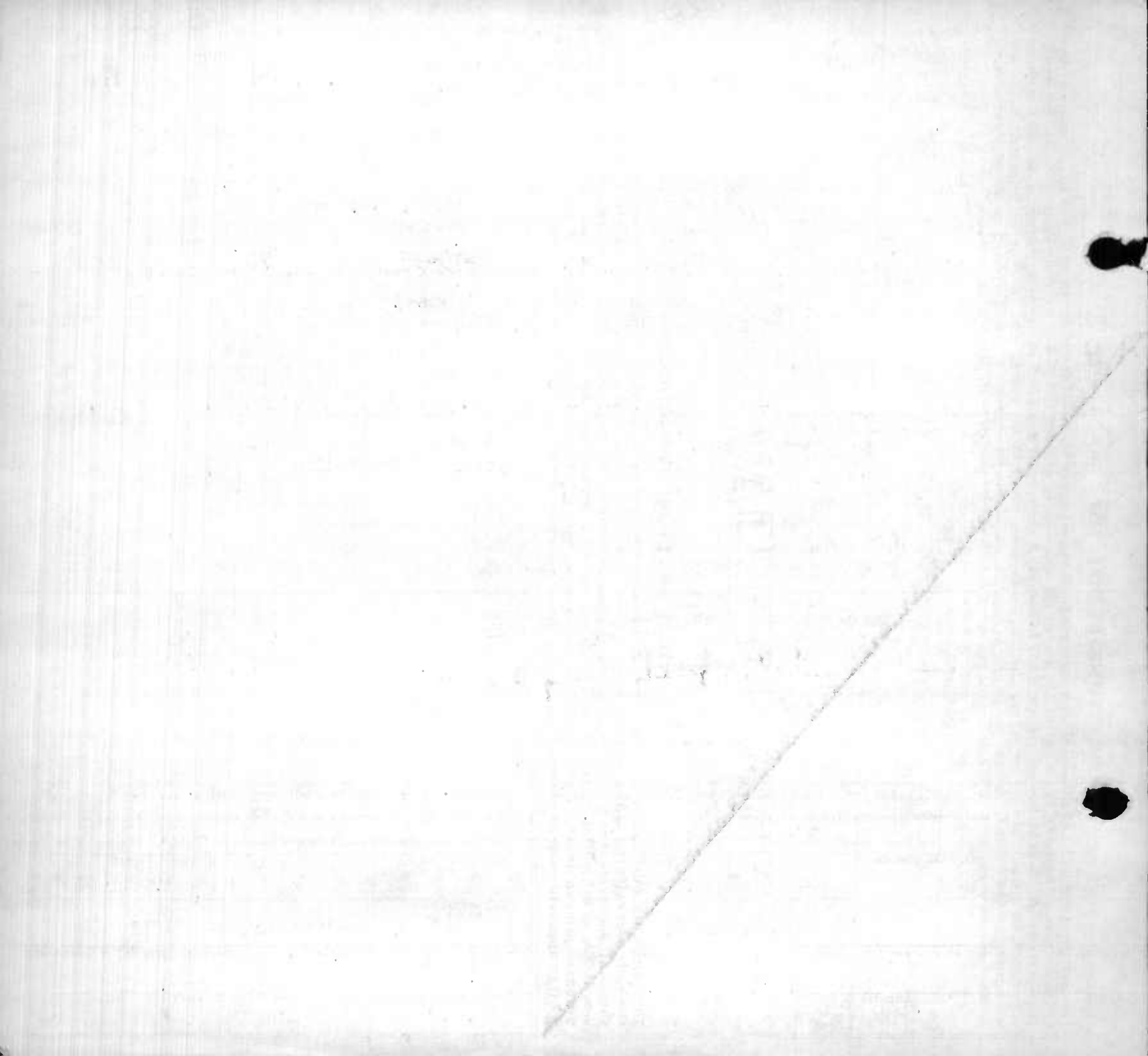
7922 Wise Ave. Dundalk, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | Registered No. 65 9999 | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------|--|
| BIRTH NO. | | 65 9999 | | CERTIFICATE OF DEATH | |
| M.E. CASE NO. | | 1. NAME OF DECEASED (Type or Print) | | 2. DATE AND HOUR OF DEATH | |
| | | DUB, MICHAEL also known as Emilian Marchuk | | Sept. 28, 1965 2:45 A M. | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND | | | | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) | |
| FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital | | | | A. STATE Maryland | |
| | | | | B. COUNTY | |
| 5. SEX Male | | | | 6. RACE White | |
| 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Single | | | | 8. DATE OF BIRTH 8-19-95 | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man | | | | 11. BIRTHPLACE (State or foreign country) Russia | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. 212-10-2008 | |
| 17. INFORMANT Mr. Harold E. Davis, 1901 Bank St. | | | | ADDRESS | |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. | | | | CAUSE OF DEATH (A) Myocardial Infarction DUE TO (B) DUE TO (C) DUE TO | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | Cirrhosis | |
| 19A. DATE OF OPERATION | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) None | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I certify that (I) (this hospital) attended the deceased from Sept. 27, 19 65 to Sept. 28, 19 65, that (I) (we) last saw the deceased alive on Sept. 28, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (do not) view the body after death. | | | | | |
| 23A. SIGNATURE Jose D. Manalo | | | | 23B. DATE SIGNED Sept. 28, 1965 | |
| 23C. PHYSICIAN'S NAME (Type) Jose D. Manalo | | | | 23D. ADDRESS 1400 N. Caroline Street- 21213 | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial | | 24B. DATE 10/1/65 | | 24C. NAME of CEMETERY or CREMATORY St. Stanislaus | |
| | | | | 24D. LOCATION Baltimore, Maryland | |
| 25A. DATE REC'D BY HEALTH DEPT. SEP 28 1965 | | 25B. NAME OF REGISTRAR M.F. SADOWSKI & SONS | | 25C. FUNERAL DIRECTOR ADDRESS 1808 EASTERN AVE | |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT | | | | | | | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|--------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|--------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|--------------------------------------|-------------------------------------------------|--|
| BIRTH NO. 65 10000 | | | | | CERTIFICATE OF DEATH | | | Registered No. 65 10000 | |
| 1. NAME OF DECEASED (Type or Print) <i>SHERMAN, Winfield S.</i> | | | | | 2. DATE AND HOUR OF DEATH <i>29-Sep-65 12:50 A.M.</i> | | | | |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>MARYLAND GENERAL Hospital</i> | | | | | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>BALTIMORE</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTIMORE 12-03</i> D. STREET ADDRESS (If rural, give location) <i>2620 GILFORD Ave.</i> | | | | |
| 5. SEX <i>MALE</i> | 6. RACE <i>White</i> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i> | 8. DATE OF BIRTH <i>11-30-98</i> | 9. AGE (In years last birthday) <i>66</i> | If Under 1 Yr. Months Days | | If Under 24 Hrs. Hours Min. | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Dept of Motor Vehicles</i> | | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Dept of Motor Vehicles</i> | | 11. BIRTHPLACE (State or foreign country) <i>VIRGINIA</i> | | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>John S. SHERMAN</i> | | | | | 14. MOTHER'S MAIDEN NAME <i>Bell Unknown</i> | | | | |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i> | | | 16. SOCIAL SECURITY NO. <i>213-12-9988A</i> | | 17. INFORMANT <i>Hospital chart</i> | | | ADDRESS | |
| 18. <i>420.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | | | CAUSE OF DEATH (A) <i>Acute MYOCARDIAL INFARCTION</i> DUE TO (B) <i>Arteriosclerotic heart disease</i> DUE TO (C) <i>Pulmonary edema</i> | | | INTERVAL BETWEEN ONSET AND DEATH <i>5 hr</i> | |
| 19A. DATE OF OPERATION <i>0</i> | | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20A. AUTOPSY? (Yes or No) | | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> | | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | | | | |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) | | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | | | |
| 22. I certify that (X) (this hospital) attended the deceased from <i>28-Sep-65 10pm</i> to <i>250AM 29-Sep-65</i> , that (X) (we) last saw the deceased alive on <i>29 Sep</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. | | | | | | | | | |
| 23A. SIGNATURE <i>Thomas Carlton Cullis</i> | | | | | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> | | 23B. DATE SIGNED <i>29-Sep-65</i> | | |
| 23C. PHYSICIAN'S NAME (Type) <i>THOMAS CARLTON Cullis</i> | | | | | 23D. ADDRESS M.D. | | | | |
| 24A. BURIAL CREMATION, REMOVAL (Specify) | | 24B. DATE | | 24C. NAME OF CEMETERY or CREMATORY | | 24D. LOCATION (City, town, or county) (State) | | | |
| <i>Burial</i> | | <i>9/30/65</i> | | <i>Speciation</i> | | <i>Barford Co. Md</i> | | | |
| 25A. DATE REC'D BY HEALTH DEPT. <i>SEP 30 1965</i> | | 25B. NAME OF REGISTRAR <i>Robert E. Fairbank</i> | | 25C. FUNERAL DIRECTOR <i>Stewart-Hornum</i> | | ADDRESS <i>108 W York</i> | | | |

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